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MEDICARE AND MEDICAID

HEARINGS

BEFORE THE

SUBCOMMITTEE ON MEDICARE-MEDICAID

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

PART 2 OF 2 PARTS

APRIL 14 AND 15, MAY 26 AND 27, JUNE 2, 3, 15 AND 16, 1970

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- Robert Ball, Commissioner of Social Security;
- Arthur Hess, Deputy Commissioner of Social Security;
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- Robert Myers, Chief Actuary, Social Security Administration;
- Henry Spiegelblatt, Director, Program Management Division, Social and Rehabilitation Service, Medical Services Administration;
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MEDICARE AND MEDICAID

TUESDAY, APRIL 14, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 2221, New Senate Office Building, Senator Abraham A. Ribicoff, presiding.

Present: Senators Long, Talmadge, Ribicoff, Byrd, Jr., of Virginia, Williams of Delaware, and Curtis.

Senator RIBICOFF. The hearing will come to order.

For many months, the Committee on Finance has been conducting an extensive review of the medicare and medicaid programs. Because of the importance of the issues raised by these programs—highlighted by official estimates of long-range cost overruns of $216 billion and sharply rising part B premiums in medicare—there has been created a special ad hoc subcommittee to concentrate its attention on these programs.

The purpose of the subcommittee is to determine the problems confronting these programs, analyze them, and seek solutions so that medicare and medicaid can do a better job—and a more economical one—of meeting the needs of our older population.

Today we are going to hear from some of the carrier organizations who administer part B of medicare—the supplementary medical insurance plan for payment of doctor bills. Tomorrow we will hear from the intermediaries who are concerned with paying medicare's hospital, extended-care facility, and home health agency bills.

These are the private companies and organizations to whom the Federal Government has entrusted the responsibility for proper disbursement of billions of dollars in public funds. These are the agents to whom millions of social security beneficiaries justifiably look for prompt and fair servicing of their medicare claims.

The recent report of our staff, as well as reports of the Department of Health, Education, and Welfare, clearly indicate that some carriers and intermediaries are not fully discharging, or efficiently meeting, their responsibilities to the Federal Government and medicare's beneficiaries. Other carriers and intermediaries, however, are doing an excellent job—sometimes under most difficult conditions.

If we can learn the causes of dissimilar performance by carriers and intermediaries entrusted with similar responsibilities, then perhaps we can insure a more smoothly functioning system of settling claims under the medicare program. This, in turn, can help eliminate much of the dissatisfaction expressed by doctors that their medical

judgments are being unfairly questioned by nonmedical personnel. Similarly, a more smoothly functioning payments system can help dispel complaints by beneficiaries that medicare is not paying what they believed it would pay.

We will be also interested in finding out from carriers and intermediaries which aspects of the medicare legislation, regulations, instructions, and social security administration they believe to have hampered efficient administration of medicare. We will be interested to hear any general or specific recommendations they may have for improvements in medicare's present structure and operation.

The first witness this morning is a panel of spokesmen representing the carrier group of the Health Insurance Association of America. Will those who represent the carrier group please come forward and take places at the witness table?

Senator Williams, any comments you would like to make?

Senator Williams. No, thank you.

Senator Ribicoff. Senator Talmadge.

Senator Talmadge. No, sir.

Senator Ribicoff. We will include at this point in the record the committee's press release announcing the formation of the new ad hoc subcommittee.

PRESS RELEASE

FOR IMMEDIATE RELEASE
March 23, 1970

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 New Senate Office Bldg.

COMMITTEE ON FINANCE ANNOUNCES MEDICARE - MEDICAID SUBCOMMITTEE

Senator Russell B. Long (D., La.), Chairman of the Committee on Finance, announced the formation of a five-member ad hoc subcommittee to continue the Committee's legislative oversight inquiry into the Medicare and Medicaid programs.

He reported that at his request, Senator Clinton P. Anderson (D., N.M.) agreed to serve as Chairman of the Subcommittee. The Finance Committee Chairman said: "No Senator is better qualified to direct this vital subcommittee effort than the 'father of Medicare', Senator Clint Anderson. Senator Anderson is justifiably proud of his 'child' but as any responsible parent he wants to make sure that it grows up properly." Other members of the subcommittee will be Senators: Russell B. Long; Abraham Ribicoff (D., Conn.); John J. Williams Rep., Del.); and Wallace F. Bennett (Rep., Utah). The subcommittee membership includes the Finance Committee's ranking Senators along with Senator Ribicoff, a former Secretary of Health, Education and Welfare.

Both Senators Long and Anderson noted that the subcommittee structure offers an opportunity for sharper and more extensive focus on the serious problems confronting the two Federal health care financing programs during the continuing hearings on Medicare and Medicaid.

Senator Anderson emphasized that the search for control over the costs of these major health programs has been and would continue to be conducted on a bipartisan basis. In that regard, he said: "All members of the subcommittee share common concerns with respect to Medicare and Medicaid. Those programs are worthwhile and are here to stay, but they are experiencing serious and costly difficulties which require responsible action. These difficulties can be corrected if we act promptly, and Medicare will be a better program for it. I think we are all generally agreed that we will not vote the new taxes which have been requested to cover the enormous deficit in Medicare's financing without first attempting to develop appropriate and effective means of moderating Medicare's runaway costs. The subcommittee and the full Committee are fully prepared to meet their responsibilities to the Senate -- to the taxpayers -- and to the beneficiaries who depend upon Medicare and Medicaid. We will be fair -- but we will be firm."

Senator Long stated that the Medicare-Medicaid subcommittee would hold hearings on Tuesday, April 14 and Wednesday, April 15, at which time it will hear from the private health insurance companies who function as intermediaries and carriers in the administration of Medicare.

PR #51

Senator RIBICOFF. Will you gentlemen identify yourselves and the company you represent?

STATEMENT OF WILLIAM C. WHITE, JR., VICE PRESIDENT, GOVERNMENTAL HEALTH PROGRAMS, PRUDENTIAL INSURANCE CO. OF AMERICA; ACCOMPANIED BY BEN PATTERSON, VICE PRESIDENT, HEALTH INSURANCE BENEFITS, MUTUAL OF OMAHA INSURANCE CO.; AND PAUL HAWKINS, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. WHITE. Mr. Chairman, I am William C. White, Jr., vice president, governmental health programs, Prudential Insurance Co. of America. I am accompanied by Mr. Ben Patterson, vice president, health insurance benefits, Mutual of Omaha Insurance; and on my right, Mr. Paul Hawkins, Washington Counsel of the Health Insurance Association of America. We hoped to have Mr. Halverson, who is executive vice president of the Occidental Life Insurance, and chairman of the committee, but he is unavoidably detained in Chicago. Mr. Patterson is vice chairman of the committee, and chairman of the governmental relations subcommittee.

The medicare administration committee is composed of representatives of the following insurance companies:

Aetna Life & Casualty
Mutual of Omaha Insurance Company
Nationwide Mutual Insurance Company
The Prudential Insurance Company of America
The Travelers Insurance Company
Connecticut General Life Insurance Company
Continental Casualty Company
Equitable Life Assurance Society of the United States
General American Life Insurance Company
Metropolitan Life Insurance Company
Occidental Life Insurance Company of California
Pan-American Life Insurance Company, and
Union Mutual Life Insurance Company

Collectively, these 13 carriers administer part B—supplementary medical insurance—benefits for approximately 8 million beneficiaries, including all railroad retirement beneficiaries, who are served by The Travelers Insurance Co. The first five companies named also serve as fiscal intermediaries for hospitals, home health agencies, and extended-care facilities under part A—hospital insurance benefits.

Just about 4 years ago we were tooling up to begin administration of medicare. There were many problems in the beginning, and perhaps the most important one at that time was finding the means to handle the tremendous volume of claims submitted by beneficiaries. Mistakes were made, as could be expected in the initiation of any new program of this magnitude.

The law is a complex one, requiring interpretations in the form of regulations and procedural rules, many of which could not be developed until there had been some practical experience in administering the program.

We have been privileged to have the support and cooperation of the Bureau of Health Insurance of the Social Security Administra-

tion. Also, as carriers and intermediaries, we have worked closely with the organizations representing the providers of health care.

Despite the problems encountered in launching such a massive program of health-care financing, substantial progress has been made during the past 4 years. We have become more efficient, thereby reducing the processing time for claims. Also, we have been able to develop better methods of determining reasonable charges on which benefit payments are based.

We believe that medicare has been a fine program for the elderly beneficiaries and are proud that we have a part in its administration.

As in any program of the tremendous size and scope of medicare, there are numerous improvements which can be made both in administration and in benefits. Your committee's staff has presented a report making recommendations in these areas, and we welcome the opportunity to comment on this report and also to make additional recommendations which we hope will be helpful to the committee.

In the interest of orderly presentation, we are dividing our testimony into two sections, one referring to part A and the other referring to part B.

Part A

Extended-care benefits: One of the most serious problems arising under part A stems from the extended-care provision of the law. One of the major problems is created by the misunderstanding by physicians, providers, and beneficiaries of the limited scope of extended-care services for which the program provides benefits. There is a general impression that the program provides benefits for general nursing-home care rather than only the continuous skilled nursing care, which is really an extension of acute hospital care, as provided in the law. This creates serious and costly difficulties in the administration of the program.

It has been said that as many as 50 percent of medicare patients discharged from hospitals to extended-care facilities do not require the continuous skilled level of care for which benefits are provided. However, a large percentage of these people do require intermittent skilled or semiskilled care in an institutional setting.

Unless these people, for whom the program has provided the financial means to be treated in a hospital during the acute stage of their illness, have adequate resources, they are left financially stranded with respect to these services which are necessary to their medical welfare if they are denied extended-care benefits.

As a result of this void in the program, some patients undoubtedly are being confined to higher cost, short-term hospitals longer than necessary simply because it is known that the intermittent skilled or semiskilled convalescent services required will not be covered by medicare upon transfer of the patient to an extended-care facility. This is inevitable since physicians must take into consideration both the medical and financial needs of their patients, and quite often the dividing line between the two is a very fine one.

Recognizing the realities of the situation and in an attempt to provide an extended-care benefit that is more acceptable to providers, physicians, and the public, and at the same time make it more administratively feasible, we are attaching for your consideration (ex-

hibit 1) our recommendations for amending the extended-care benefit structure.

Reimbursement of institutions providing medical care: Many of the part A problems cited in the staff report, such as delayed cost reporting, audits, final settlements, low occupancy, standby cost, collection of bad debts, et cetera, could, we feel, be alleviated by changing the approach to provider reimbursement. We share the view that providers should be reimbursed prospectively on the basis of a rate negotiated at the beginning of each fiscal year with some adjustment provision for unavoidable increases in cost. The rate would, of course, be related to a provider's past cost experience.

This approach to provider reimbursement should also reduce the high administrative cost associated with annual on-premise audits of provider's costs and should facilitate more adequate forecasting of program costs. It would also permit sounder fiscal planning on the part of providers, as they would not have to wait until several months after a fiscal year to learn of the amount of reimbursement to which they are entitled.

CERTIFICATION OF EXTENDED-CARE FACILITIES

As indicated in the staff report, the Congress intended that extended-care facilities meet requirements of high quality, and the "conditions of participation" set forth by the Department of Health, Education, and Welfare were consistent with this intent.

These standards were not always required in the early days of the program in the certification of some nursing homes as extended-care facilities. Rather, as the staff report indicates, "substantial compliance" and progress toward full compliance justified certification.

We recommend, in line with the staff report, that, for all new facilities, all conditions of participation be met by the institution prior to its certification. In regard to those facilities that are still in "substantial compliance," a specific period of time should be given for them to obtain full compliance or to have their certification withdrawn.

One of the problems which intermediaries have faced in administering the extended-care portion of the program is that certain extended-care facilities, after having been certified, have been discovered to be lacking in financial responsibility and, in addition, to have entered into financial arrangements which have been detrimental to the cost of the program. We recommend that a precertification financial audit be required on all new facilities.

INSTITUTIONAL UTILIZATION

Generally speaking, we feel that the provisions of the law setting up a utilization review structure are satisfactory. However, it is felt that the present procedure can be strengthened by administrative action rather than further amending the law. Our committee is in the process of studying and preparing recommendations to the Bureau of Health Insurance for increasing the effectiveness of the utilization review process.

A suggestion made in the staff report we endorse for your serious consideration. That recommendation is to the effect that, by appropriate Federal and State legislation, health care practitioners would

be exempted from legal liability for decisions made during required utilization review or medical audit activity.

We feel that such a provision would encourage individuals serving on utilization review committees to more freely exert their judgment than might be the case where a threat of possible legal action might exist.

HOMEMAKER BENEFIT

It is suggested that the homemaker benefit proposed in the committee staff report, while being a benefit which might be well received by the beneficiary, is more within the purview of a social welfare program than a health-care program and would perhaps be even more difficult and expensive to administer than the present extended-care benefit.

Part B

PAYMENTS FOR PHYSICIANS' SERVICES

The law provides that payments for physicians' services shall be based on the customary charges for the individual physician, taking into consideration the prevailing charges in the locality for similar services. We believe in this concept in order to assure the elderly beneficiary access to quality medical care, free choice of physician, and adequate protection against the expense incurred for physician services.

The law also provides that the physician's charge must be reasonable and not higher than the charge applicable for a comparable service and under comparable circumstances to the policyholders of the carrier. All of us are using these parameters in our reasonable-charge determinations. With the passage of time under the program, we have been able to more completely develop individual physician's customary charges and have standardized our calculation of prevailing charges. Also, through various techniques, we do compare the charges we recognize under medicare with the charges recognized in our private health insurance business.

We can assure you that medicare charges do not exceed the charges we recognize in the calculation of private health benefits. In fact, in some situations the medicare charges are below the charges recognized in our own business.

Understandably there has been concern about the escalation in physicians' charges over the past several years. Beginning in January 1969, an arbitrary limitation was established for prevailing fees and for the recognition of increases in the physician's customary charge. It seems evident that there must continue to be some means of controlling the rate of escalation in the future.

The benefit limit under medicare in paying for a physician's services is the prevailing charge. "Prevailing" can be defined in many ways, and we agree that it is time to arrive at the most appropriate definition, with full disclosure of this definition to both the beneficiaries and the physicians.

At the same time it must be recognized that any governmental action that widens the gap between what is allowed under medicare as a benefit, and the charging practices of physicians for the entire community, causes the elderly beneficiary to suffer an increasingly severe personal financial obligation.

PAYMENTS TO "SUPERVISORY" PHYSICIANS IN TEACHING HOSPITALS

We recognize that the determination of appropriate benefit payments to be made for services rendered by supervisory physicians in teaching hospitals has been a most vexing problem. Under existing administrative procedures, no benefits should be paid unless there has been a personal identifiable service performed by a physician. While this may be a desirable goal, it has been most difficult to attain.

A different administrative approach whereby the determination of physician services to be covered, and in what amount, would depend on individual billing by the physician rendering the service seems to be a practical solution.

THE QUALITY OF ADMINISTRATION OF MEDICARE

Through the early organization of the carrier representative group and the fiscal intermediary group, continuing relationships have been established with the Bureau of Health Insurance for the discussion and consideration of administrative problems. These two operations have evolved until at the present time a satisfactory working arrangement exists.

One unresolved problem which is mentioned in the staff report involves the collection of data and statistics, and the useful evaluation of these elements insofar as the carriers and intermediaries are concerned. We agree with the first three recommendations in the staff report (pages 21, 22). We also agree with recommendation No. 4 if it is clearly understood that the carriers and intermediaries must maintain certain data in order to properly administer the programs.

In conclusion, may I submit one general comment. From our experience with the administration of the medicare program, we have found a great need for more education of beneficiaries and their families. The general impression left by the literature describing the benefits is that all health-care services are covered under medicare but, of course, this is not true.

It is pointed out in our testimony with respect to the extended-care benefit that the situation is particularly aggravated because the beneficiaries believe that they are entitled, without qualification, to 100 days of benefits in extended-care facilities. This applies in more or less degree to all other benefits provided by the law.

In addition to clarifying the benefits provided under medicare, it is essential also to emphasize to the beneficiary that it is to his benefit to judiciously use, and not abuse, the health services that are covered benefits.

In addition to the comments which we have made, we are attaching for the consideration of the committee additional recommendations, both legislative and administrative, which we believe would clarify and improve the administration of the program, and those recommendations are attached as exhibit 2. Thank you, Mr. Chairman.

(The documents referred to—exhibits 1 and 2—follow:)

EXHIBIT 1

SUGGESTED AMENDMENTS TO THE EXTENDED CARE BENEFITS STRUCTURE

It is suggested that the following recommendations be explored toward amending the present extended care services benefit structure to:

1. Eliminate the continuous skilled care requirement.
2. Provide benefits for post-hospital institutional extended care services upon certification and appropriate recertification by the attending physician that they are necessary to the health of the patient.
3. Reduce the up to 100 extended care days for each benefit period to on the order of 40 or 50 days with the coinsurance feature applicable to the last one-half of the allowable benefit period.

It is suggested that the results to be expected would be:

1. Better understanding of the coverage.
2. Reduced cost of administrative and total claims expense.
3. Encouragement of the transfer of patients from hospitals to lower cost extended care facilities.
4. Elimination of some of the extended care facility reluctance to accept Medicare patients because of the uncertainty of entitlement.
5. Elimination of numerous individual judgments and better assurance of more uniform and equal treatment to all beneficiaries under the program.

Other suggestions, the desirability and feasibility of which could be explored, are that the law be amended to provide that:

1. Through certification by the attending physician upon patient discharge from the hospital, that care in an extended care facility is medically necessary, no further determination need be made about the level of care provided in a certified extended care facility.
2. Payment for such care in such a certified institution would be made in full for up to 20 days, and
3. Upon further physician certification that continued care in that facility is a medical necessity an additional period of up to 30 days of care will be provided with the patient responsible for a daily coinsurance amount equal to one-fourth of the Part A hospital deductible.

It is further noted, that a change in the ECF reimbursement system whereby on-site audits will not be required, or required only every third or fourth year, seems mandatory if administration costs are to be significantly reduced.

EXHIBIT 2

LEGISLATIVE AND ADMINISTRATIVE RECOMMENDATIONS FOR IMPROVEMENT OF MEDICARE

Maintenance of eligibility and deductible file

Each Part B carrier should maintain the eligibility and deductible file for each individual residing in the geographical area subject to that carrier's administration.

This procedure was urged by insurance company carriers in the formative period of the administration of the law. It is firmly believed that such a provision adopted now would simplify administration, eliminate the query system with Baltimore each time a claim is presented, eliminate duplicate records in the carrier's office, speed up the processing time in settling claims, eliminate the need for the carrier to go to the Social Security district office for information, reduce personnel in both the district offices and Baltimore, and provide a less confusing procedure for the beneficiary, who, under such a system, would identify himself with a single carrier.

Two objectives which all are interested in obtaining are to speed up service to the beneficiary in paying claims and to reduce the administrative cost of the program. Allowing carriers to maintain their own records as indicated above would be a great step toward these two goals.

Some have indicated that they fear the carriers would use the information obtained under this procedure for the purpose of soliciting sales of private insurance, etc. Such would be most impractical, specifically because of the age

group involved, and also because the same information might be obtained in other ways if it were thought to be desirable. Thus, there is little or no obvious objection to the adoption of this proposal in the interest of economy and efficiency; however, it appears that in order to achieve the desired arrangement, legislation is required.

Elimination of deductible carry-over provision

Amend Section 1833(b) by striking (a)(1).

Existing law provides for a $50 annual deductible for each Medicare beneficiary. There is, however, a special provision to help the beneficiaries who might otherwise have to meet the $50 annual deductible twice in a short period. This special provision, known as the "carry-over," permits the same expenses credited toward the $50 annual deductible during October, November, or December of any year, to be credited again toward the deductible for the next year.

If for the year expenses for covered services are $50 or less, then any expenses for covered services that the beneficiary has in October, November, or December of that year count toward the $50 annual deductible for the next year. Because this provision in the law is so difficult for beneficiaries and physicians to understand, with resulting confusion, it is recommended that the carry-over provision be eliminated. Elimination of this provision will not only simplify the explanation of the $50 deductible to beneficiaries and physicians, it will also result in substantial savings in the administration of the Program.

Revision of provision for payment of benefits on behalf of deceased beneficiaries

Amend Section 1870(f)(2) to read as follows:

"(2) payment for such services has not been made, payment for such services *may* be made *jointly to an eligible relative* (as defined in (e)) and the physician or other..."

The provision of Section 1870 providing for the settlement of claims for benefits on behalf of deceased individuals was passed prior to the amendments to Section 1842 which provided for the payment of benefits on submission of an itemized bill. When provision for payment of an itemized bill was enacted, it is felt that an oversight occurred in not amending Section 1870(f)(2) to provide a method of payment when an eligible relative presents an itemized bill on behalf of a deceased individual. In many of these situations the physician will not accept an assignment as provided in Section 1870(f)(2) and it is a burden on the relative to require payment of the bill in order to collect benefits. Therefore this amendment is recommended to protect the integrity of the Program, ease the burden on the relative, protect the physician, and ease the administrative burden of the carrier.

Revision of fair hearing procedure

Amend Section 1842(b)(3)(C) to read as follows:

"(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier when requests for payment *in excess of $100* under this part. . . ."

Presently there is no minimum limitation on the amount upon which a beneficiary may demand a fair hearing. Experience has demonstrated that a number of costly hearing procedures have occurred on items amounting to pennies. It is noted that a minimum of $100 is already in the law for fair hearings under Part A.

Payment of reasonable charges for outpatient physical therapy

Amend Section 1832(a)(2) by striking (C).

Part B administration is on the basis of determining reasonable charges. In administering this provision, it is necessary to establish an expensive and time-consuming system of cost determination and audits outside of the regular Part B administration. It is felt that economy in administration and personnel would result from placing outpatient physician therapy on the same basis of payment as other Part B services.

Hospital-based physicians

A difficult problem in administration results from the present language in Section 2832(a)(2)(B). This section provides that payment will be made for Part B beneficiaries and physicians for medical and other health services. However, it also provides that residents and interns of hospitals who render such services and are salarized shall receive payment under Part A. The difficulty arises because there are physicians in numerous specialties who derive their compensa-

tion either through salaries or other arrangements from the hospital. However, a portion of this compensation may be for services rendered to the institution rather than for patient care services. This requires an allocation of the physician's compensation between the Part A and Part B trust funds. Because of the difference in arrangements which are made under these circumstances, each of which requires individual determination, sometimes without the approval of either the hospital or the physician, extensive expenditures of time and money become necessary. It is therefore recommended that serious consideration be given to proposing an amendment which would provide that payment of benefits be made entirely from the Part A trust fund to those physicians who are compensated by the hospital and entirely from the Part B trust fund for physicians billing on a fee-for-service basis.

Ambulance benefits

Under present interpretation of the law, payment of benefits for the use of an ambulance is made only for transportation of the beneficiary to the nearest facility regardless of the medical staff available at that facility. As many times happens, the nearest facility to the beneficiary may not have adequate medical staff to care for his particular illness or injury, or for other reasons not under control of the beneficiary, he is transported to other than the nearest facility. Denial of benefits under such circumstances seems unfair and causes severe problems in administration. The law should be changed so that if a patient must go to other than the nearest facility, payment should be made for the equivalent of transportation to the nearest facility.

Senator Long. Let me ask this as a starting point: Do you know of anything which we might do to assure better utilization in medicare? What would you suggest?

Mr. White. Well, the last part of my statement is one project we think should be undertaken to educate all persons involved—beneficiaries, their relatives, providers, and physicians—as to the law's provisions. There is a great misunderstanding among all parties about what the law pays for.

For example, in the nursing homes which are certified as extended-care facilities, people believe that, since it is a skilled-nursing home, therefore any care they receive there is skilled care and should be covered. I am not arguing they are not receiving it, but we can only pay benefits according to the law which requires continuing skilled-nursing care.

This is a big area, costly area, and very much misunderstood, and there should be education along this line.

Senator Long. You are with the Prudential Co. I see your company's name on television from time to time. Might it not arrange some commercial spots to tell people what they are and are not entitled to under medicare? Is that idea worthy?

Mr. White. I understand TV stations do provide time for public-service announcements, and I think that would be helpful.

Senator Long. I have my doubts about doing this on the basis of free time anyway. I am inclined to think some of this ought to be put on prime time and paid for so as to be sure somebody would see it. Those free spots usually go on some program that most people don't look at anyway. If it is worth doing, we can afford to pay for it, I would think. Again, do you think it might be helpful to find some way to advertise to people: "Here is what you are entitled to and not entitled to"?

Mr. White. I think it would.

Senator Long. This thought has occurred to me. I think it might have helped to have done business with your company to begin with. What would be wrong with just making a contract with a company

like yours which said: "Here is what we want you to provide, and here is x number of dollars multiplied by x number of patients." That is what insurance usually amounts to. You collect so much money, and you have a contract to provide certain services, and you take the risk that you will make or lose money. Then the burden is on you to obtain those services at a reasonable cost. What would be wrong with that approach?

Mr. WHITE. Certainly it would be possible to do that. However, Mr. Chairman, you must understand that is no pot of gold the insurance companies have, so if the costs go up, we have to come back and ask for an increase in premium, which is, in fact, the way group health insurance now operates.

Because of the increasing cost, especially of hospital care, my company and other companies in the major health insurance business are raising premiums continually because we have no raises in cost any more than the Government does.

Senator LONG. There has been feeling on the part of the staff that some of the carriers—and I don't point the finger of scorn at any particular one, because it would be unfair—a finding on the staff's part that there have been quite a few carriers who didn't feel it was their duty and responsibility to hold medicare costs down and to make payments at the most reasonable prices.

Wouldn't pressure be directly on the company if you had a contract for a given number of people—let us say your company had 1 million people to look after and that we are going to pay you so much multiplied by 1 million people. Would that approach help to keep pressure on companies to obtain services on a reasonable basis?

Mr. WHITE. Certainly the company, if we were in a risk, would have to make every effort possible to hold down costs; but, on the other hand, we are in the same position now in our private business, and as long as we are paying benefits similar to medicare—for example, paying full care in the hospital, as compared to the old type of contract where we pay so much a day—as long as we are agreeing to pay to protect the patient against full cost of hospitalization, no matter how hard we work we have no way to control escalation.

Senator CURTIS. May I ask a brief question? You refer to paying so much per day as the old type of contract?

Mr. WHITE. Yes; but we don't sell many many more.

Senator CURTIS. Are any private insurance companies abandoning that?

Mr. WHITE. The major portion of group health sold today is in the major medical field, and we have abandoned the fee-schedule approach and, in effect, provide service benefits. In other words, we pay reasonable charges, much as the wording of the present medicare law. There will be an overall aggregate limit, $20,000 or $30,000 in total, but within the aggregate we have this situation.

Senator CURTIS. But in hospital care, do you write policies pledging to pay the reasonable cost of hospital or insure for a specific dollar amount per day?

Mr. WHITE. In most of the medical policies, we agree to pay the full charges the patient incurs in a semiprivate room, either up to maximum amount or given number of days, which is very much like medicare, except that we are paying charges.

Senator CURTIS. That is your major way?

Mr. WHITE. Yes.

Senator CURTIS. I am speaking of your overall hospital insurance.

Mr. WHITE. We still do have policies available, although we don't sell as many as we do the other. You can buy $20- or $25- or $30-a-day hospital benefits, but most of the people prefer a major medical, which, of course, gives more protection.

Senator CURTIS. Mr. Chairman, that is all.

Senator LONG. It seems to me that the efficient way to finance medical services on a group basis is about the way I have seen some groups of employees working for a large corporation do it when they join together. I recall a particular health plan right in my hometown. These employees get together and put in a certain amount of money—every fellow puts up his contribution—and then they go to work and hire for themselves one or more doctors. They have perhaps several doctors in a clinic, and one doctor will specialize in one thing and the other specializes in something else, thus hoping to provide a complete service.

If they have to go outside of the available specialties, they have in mind whoever the best consultant or specialist will be beyond what they have to offer and they use his services on a time-to-time or as-needed basis. They pay their doctor a salary and something also for possible use beyond what is anticipated. They make the best deal they can, and they try to get the best doctor they can get. They usually wind up hiring somebody very good. Even though the man they get may not have the most experience or be the most well-known doctor in town, by the time they hire they have some fellow who seems to be good and has experience and all of the business he can handle day in and day out; and, if he wants to quit, he could go out and make a lot of money because he has all of the clinical practice a man expects in his specialty and is good and has a fine reputation.

Now, why couldn't that approach be used to help provide efficient and reasonable-cost medicare for these elderly people?

Mr. WHITE. Well, certainly it is possible. I think there is one difficulty; you can't always set these up. First of all, you can't always find doctors to participate. Secondly, there is a problem if you do get one group of doctors to agree to this you have to have service for a widespread area, the beneficiaries spread out, they might not like to travel so far. This is where they might go to a doctor down the block who does not belong to the group. I think you are right; this might be a good approach if it could be achieved.

Senator LONG. Please pardon my ignorance. Where is the headquarters of Prudential?

Mr. WHITE. Newark, N.J.

Senator LONG. In the particular city there, in the Newark area, couldn't your company contract with enough doctors to the point where the people in that area would have somebody available to them who would be reasonably convenient?

Mr. WHITE. I don't know if we could do it or not. We have no experience.

Senator LONG. As I say about many things, maybe that won't work but we ought to try something if what we are doing is not working well.

Now, the administration has proposed limited medicare payments under part B to the 75th percentile of charges. Exactly how does it work, and do you think it would be effective?

Mr. WHITE. Well, you have the whole array of charges, let us say, for an office call. In this distribution, you stop at the 75th percentile, which is 75 percent of those charges, and that would be the top that you would pay. In other words, it would be defining the prevailing charge which is the limit under the law as the 75th percentile.

Senator LONG. How effective has that type of procedure been in limiting medicare expenses up to this point?

Mr. WHITE. At the present time under medicare, we are not using the 75th percentile as a mean-plus-one standard deviation, which is roughly 83 percent, and it has been an effective limit. As I mentioned in my statement, we have this situation.

Senator LONG. You might explain how it worked; how has it done that?

Mr. WHITE. We do it actually on the computer. We have in the computer a record of the physicians' customary charges by locality for each different kind of procedure, so the computer does the statistical calculation of arriving at the mean, the average, plus one standard deviation above that, and in the computer that is set as the cutoff point. We will pay the doctor's customary fee if it is below that, but if his fee gets up to that point or above we cut off at that point automatically.

Senator LONG. Do you think it has been an effective method of helding down medicare expenditures by all carriers or just with regard to your company?

Mr. WHITE. I can only speak for myself and our committee, and I know our committee has discussed this and we are following the procedure set down by the Social Security Administration in defining the charge and in fact freezing it since a year ago last January. We have not recalculated. Normally in the past we recalculated periodically.

Senator LONG. I have one more question. A noted actuarial firm, Milliman & Robertson, reported to the Civil Service Commission that:

> A health care program which is reimbursing high percentages of usual and customary fees is particularly subject to inflation; thus stringent enough controls to hold down premiums cannot reasonably be expected.

Our staff obviously agreed with that statement because they recommended a scheduled allowance approach for medicare. What has been your experience?

Mr. WHITE. We are following, as I said, the definition of "prevailing" set down by the Administration. We have not recalculated for the whole year last year and up to the present time. Of course, doctors' fees are continuing to rise, so that, with the prevailing frozen, more and more medicare bills are being reduced as far as payment of benefits is concerned.

Whether you have a fee schedule or frozen prevailing, as we now have, you end up really penalizing the elderly beneficiary, because he goes to the doctor, the doctor renders the usual charge, and, as our prevailing gets farther and farther below, it leaves a larger piece of the bill for the patient to pay.

We have no control over what the physician wants to charge the public. The only thing we have control of is how much we pay in benefits.

Senator LONG. What is the doctor's "usual and customary charge"? How would you define that?

Mr. WHITE. For any given procedure, let us say for office calls, regular office call, we get bills from the physician and we calculate the median figure of all of these different quantities—$6, $7, $8: that then is set in the computer as the customary charge, and then all physicians arrayed together make up the calculation for the "prevailing."

Senator LONG. If you are buying something from the ordinary producer of any other commodity or service and you are buying it on a bulk basis, you can get the lowest cost, not the median cost. You usually get the low figure if you are buying on that basis. If you buy wholesale, you get the lowest price at which it is sold to anybody: you don't get the median price at which it is sold.

Mr. WHITE. We are not really the buyers, but the patient is the buyer of services.

Senator LONG. Yes; the point is, you are working with that amount. This "usual and customary" thing sounds satisfactory to me until I get to thinking about it, and then this thought occurred to me, and I wonder if it has occurred to you. You are buying more than a thousand times as much service as any one doctor has to offer. Therefore, one would think—at least you are paying for 1,000 times as much: let me put it that way—so then one would think you ought to know a lot more about what you are paying for and how much it ought to cost than one provider would know. He would know from his experience, but you ought to know about what it cost and what the problems are in obtaining it in a thousand times the volume than any one of these fellows can who provide it.

Mr. WHITE. We do know what they are charging. For different kinds of services, of course, they charge different prices. Again, we are not really purchasing from the doctor. This is an insurance program. We are, in effect, paying a benefit—this is, in a way, like our own business—to the beneficiary. We don't necessarily pay the doctors.

Senator LONG. Why do you want to talk about a distinction without a difference? Somebody pays you, and you provide the service, you are buying it on their behalf, you are paying for it. The question is: Who are you working for? Are you working for the fellows paying for the health service or for the guy providing it? Which one are you working for?

Mr. WHITE. I am working for the Government in providing the benefit——

Senator LONG. That is a misleading answer. Both of those two fellows—both the doctor on the one end and patient on the other, and hospital on the one end and patient on the other—they are all subject to the same government, but one man is paying and the other is collecting. Which is the one you work for?

Mr. WHITE. We are working for the fellow paying.

Senator LONG. I am happy to get that thought straight. If you had not figured that one out, I wouldn't know what you are doing here. If that is the man you are working for, it would seem to me

it is your burden to get him the best deal you can get for him. Do you agree with that or not?

Mr. WHITE. Yes; except we are not paying the doctor. We are paying the patient. The patient is incurring the charge. He comes to us and we pay him whatever the benefit is. We may pay him eight and he may pay the doctor another seven on top. We are not necessarily paying the doctor's services but reimbursing the patient for what we can pay under law for the services rendered.

Senator LONG. I thought what you were here for was to discuss with us why this program is costing twice what we thought it was going to cost and how you felt we might get the genie back inside of the bottle. I thought that is what we were talking about and I thought that was the question to you.

Mr. WHITE. "How can we get the thing under control?" My first answer is about part A, on the nursing home part, which is a serious problem, and, of course, we discussed in the testimony of prospective rates for hospitals because there again is where the costs have risen tremendously. We agree there has to be some kind of definition of "prevailing" and we ought to agree on it and publish it because the word "prevailing" can mean anything you want it to.

Certainly we as a carrier do what we are told to within the law by Social Security Administration. So whatever the rules are, we abide by, and you can set the definition any place that is reasonable.

Senator LONG. By the time we are through, if we can find where you can be doing a better job, as far as I am concerned we will tell you, and I hope you show us the same consideration whether we like it or not.

Mr. WHITE. Yes, sir; we will do our very best.

Senator RIBICOFF. What bothers me is this: When you, Prudential especially, started this out, you considered surveying the physicians that came within your contract as to what their customary charges would be. Then you rejected that. How did you arrive at what charges should be by doctors?

Mr. WHITE. I am not sure I understand the question about my "rejection."

Senator RIBICOFF. At the beginning, what determination did you make as to what a customary charge would be in the locality? What States do you have?

Mr. WHITE. At that time we had only one State, New Jersey.

Senator RIBICOFF. How do you start out with what the customary charge would be in New Jersey?

Mr. WHITE. We have quite a large amount of major medical insurance business in New Jersey, group contracts, which we had for 15 years before medicare came along, and we made a survey of the charges the doctors were rendering to people interested in the Prudential policies. That is how we started out.

As we got experience with medicare, we adjusted, we compared to see what way we were going. As a matter of fact, we found out the medicare charges were less than the charges of private policies, so we cut back on the prevailing cutoff because of that fact.

I think perhaps one of the reasons was that—the only reason I can figure out—is that, of course, these people were getting care from doctors before medicare came along, and in many cases the doctors had

not increased the charges of older people as they had to other patients, and we were running into charges less than we ran into in our own business, and that was on people who were working, in the younger ages.

Senator RIBICOFF. Then the doctors raised it. When they raised them, they then raised them not only to older patients, which was customary, but everybody, which ballooned the entire cost of health care in America.

Mr. WHITE. Yes; the costs of charges have certainly gone up in the last 4 years.

I was describing our experience that went into our own business, and that is what we put in our computer to start with.

Senator RIBICOFF. When you answered Chairman Long as to "you paid the patient," doesn't the overwhelming number of doctors get assignments from patients?

Mr. WHITE. I can first of all speak for myself. We in New Jersey have only 50 percent of assignments. Another 50 percent of the bills submitted to us we reimburse the patients rather than the doctor.

That varies all over the country, with different rates in every State.

Senator RIBICOFF. Do you find the doctors are getting the assignments, or not getting the assignments; do you find the rate they charge the patients differ whether there is a direct assignment or billing?

Mr. WHITE. No, the way it seems to work is that certain doctors always accept assignments. Certain other doctors accept assignments only in situations where they feel that the patient is below average income for older people.

But I can't see any real difference in rates charged by doctors whether it is assigned or not assigned.

Senator RIBICOFF. Have you checked that out to determine if it is so or not?

Mr. WHITE. Yes.

Senator RIBICOFF. And you find there is basically no difference?

Mr. WHITE. What I mean, they don't change. Take a given doctor, one takes the assignments, and the other one doesn't; he doesn't charge a different rate.

I tell you what happens, though, between those who take assignments as a category and those who don't. The tendency is that those who do not are the ones who are specialists or higher priced than average; therefore they do not want to be bound by the assignment, because under the assignment the doctor is bound by our determination of a reasonable charge.

Senator RIBICOFF. When did you first become aware of extensive abuse on the part of doctors or hospitals for extended-care facilities? Was the first time that you became aware of it when the Finance Committee staff report came out?

Mr. WHITE. No. First of all, the word "abuse" is hard to define. I prefer to talk about utilization, and in some cases overutilization.

In the beginning of the program, as I said, we had a computer system that we used to help us, because of the huge volume it being difficult to handle manually, to use it to determine patterns of care.

Now, in the beginning of the program, as I mentioned in my statement, the first concern was to get underway and start paying claims.

As time has gone on, we have been developing means of taking a look at patterns.

For example, every 3 months we have a printout of all physicians in our State, showing the kinds of services that are shown on his bill, how many phone calls, office calls, "ECF" visits, lab charges, and so forth.

We take a look at the pattern to see if there are patterns that look perhaps worthy of further investigation. For those physicians with a pattern at first glance appearing to be out of line, we then peruse all of the claims individually and begin to take a review of those: in some cases visit him in an effort to control utilization.

Senator RIBICOFF. You happen to be the first witness, so I am asking this question of you, although it applies to almost all. For Prudential, in New Jersey—chart 1—the comparison of medicare and Blue Shield allowances for selected surgical procedures shows the average medicare reasonable charge for a cataract is $437, and the Blue Shield maximum payment is $275.

This is what I think really bothers all of us. I think everybody here in this committee was shocked, including myself, when I saw the difference in my own State. When we looked at our own respective States, it made us deeply concerned about the abuse.

We are looking at New Jersey, and I will ask the same question when somebody from the State of Connecticut comes, because I am concerned about my own State, but let's take your State of New Jersey.

The average charge under medicare for a cataract operation is $437, and the Blue Shield maximum is $275. How do you explain it?

Mr. WHITE. Blue Shield maximum is a scheduled benefit. This does not mean that particular fee is going to provide full payment to the Blue Shield subscriber.

Senator RIBICOFF. My understanding is, from the staff, this was a service benefit.

Mr. WHITE. It is.

Senator RIBICOFF. The doctors agreed to take from Blue Shield $275 for people with incomes less than $5,000.

Mr. WHITE. Some doctors agreed, but the ophthalmologists did not.

Senator RIBICOFF. I understand from the staff that the majority of the doctors in New Jersey agreed with Blue Shield, to take it as a maximum.

Mr. WHITE. The majority. That does not necessarily mean the majority of surgeons that perform lens extraction.

I am glad you picked this one.

Senator RIBICOFF. We are going to take all, not just this one.

Mr. WHITE. This one, because of the fact the Blue Shield payment is so low, the ophthalmologists are not participating, and, as a matter of fact, Blue Shield has a contract which they sell—in fact I recall not too long ago they sold to United Auto Workers—where they pay the customary and usual charge, and I happened to talk to the Blue Shield people about this point, because they were making a big issue of it, too, and I asked, "How much do you pay on the reasonable-charge contract, forget the scheduled contract, and how much for lens extraction?" and I was told, "Up to $500."

Senator RIBICOFF. Let's go to prostate. Medicare averages $447, and Blue Shield maximum is $300.

Mr. WHITE. Actually, what I said about the first one applies all the way across the line. The Blue Shield schedule has this situation.

Senator RIBICOFF. How about dropping out after medicare started? How many of the doctors dropped out of the program with Blue Shield after medicare went into effect?

Mr. WHITE. That I don't know.

Senator RIBICOFF. What do you think the responsibility is—and I think Senator Long started this—what do you think your responsibility was, you and all of the other insurance carriers in this program? That is when you started into it.

Mr. WHITE. Our responsibility was to do the best job we could of administering the program under guidelines, directives, regulations, and so forth, within which we have to operate.

Senator RIBICOFF. But do you think you were really supervising this program?

Mr. WHITE. Well, actually, Social Security is supervising, and we are in effect a contractor operating for Social Security within the parameters, rules, and regulations, and the law. In other words, we cannot go beyond what we were told.

Senator RIBICOFF. You see, the interesting thing about this is we did not want to see a burgeoning bureaucracy in the program. I think this was the general feeling of everybody on the committee, whether conservatives, liberals, or middle-of-the-roaders: we all felt we had a large reservoir of experience in private industry—the insurance companies. They were in the health field and knew the business, and they would prevent us from having all of these bureaucrats in every town and every State. There was no better group ready and available to handle this than the insurance companies. And you were anxious to do it. Many of them thought it was a great opportunity.

We thought we were going to get all of the effectiveness and supervision of private industry, and it came as a shock to all of us when we found you were just as ineffective and inefficient and costly as any bureaucrat would probably be. Maybe it cost more to run the program under your supervision.

The feeling we seem to get as we go into all of these programs is that you didn't really care very much. I mean this was a big bag of money—billions of dollars that Uncle Sam had—and everybody was going to dip into it: doctors, hospitals, nursing homes, and insurance companies. Although we thought you would be looking out for Uncle Sam the way you were looking out for your own stockholders, in fact, we found a general sense of indifference and very sloppy management.

Mr. WHITE. I want to tell you, Senator, as far as Prudential is concerned, we would argue that, because we have tried to do a good job, and I think we have, as a matter of fact.

Senator RIBICOFF. The staff tells me Prudential was one of the better ones.

But there have been insurance companies, and the Blues, that paid every bill that came in. They never bothered or supervised or checked, as the bills came in. They rubber stamped and paid them.

Now, I want to give credit where it is due. The staff says in their study Prudential has done a good job, and I want to tell you it in all fairness, because on many of these questions you happen to be

just here representing Prudential, and many of these questions are not being leveled at Prudential. It is just as a general statement that I make, and I think it would be unfair to say I was citing Prudential, because the statement is general and not aimed at your company.

Mr. WHITE. Yes.

Again, not only speaking for Prudential, but for the committee I represent, 13 insurance companies that are involved as carriers and intermediaries, speaking especially of part B at this point, I can assure you there has been a concern.

We have this committee of 13 companies who meet together, and we have our administrative people who work for us and meet together to develop good ideas and exchange ideas on how to do a better job, and I can assure you there is concern on our part of doing a good job for the Government in this program.

That is within, of course, the law and the regulations. We can't, of course, go around the law and regulations, but we must live within those.

Senator RIBICOFF. Let me ask you this. Take your own private health business. What happens? Do you have doctors whom you contract with, or who see your patients or service your patients?

Mr. WHITE. No.

Senator RIBICOFF. Well, in other words, Jones or Smith or Brown can go to any doctor they want to and submit the bill?

Mr. WHITE. Right.

Senator RIBICOFF. Do bills come in from doctors who treat the privately insured in huge sums of $25,000, $30,000, $50,000, $100,000 a year? Do you get total bills from any doctors within that range to take care of your beneficiaries?

Mr. WHITE. You are talking about the total amount repaid to a given doctor?

Senator RIBICOFF. Yes, sir; one doctor.

Mr. WHITE. I tell you, quite frankly, Senator, I can't tell you, because we did not look at it the way we do on medicare. We have controls tighter on medicare than in our own business.

In our own private business, it is fragmented, and the claims might be administered out in the plant by the group rather than our own office, and I do not have the figures on our own business, the kind you are talking about.

Senator RIBICOFF. Let's say a bill came in to you from a Dr. Jones. On a certain day—on January 5, 1970—he sent you bills for 20 people treated that day at $8 a visit. Would that concern you at all?

Mr. WHITE. It does not come that way, because most of our bills come from our policyholders rather than from the doctor. In other words, we have a policyholder, and he brings bills in to us.

Senator RIBICOFF. Let's go to medicare, because you are a prudent company.

Let's say you suddenly see a situation where a doctor will come in for the medicare payments. There may be 20 bills for $8 a patient, or $7, for one day from Dr. Jones. What do you do about it?

Mr. WHITE. We do have, first of all, at the present time, some external controls of claims that come through, but we have a retrospective look on every doctor in the State. We have computer printouts for every doctor, showing how many office calls, lab charges, he made; how many X-ray charges, and so forth; and we set up a pattern, and

then if it appears out of line, we then get a complete printout of the doctor and investigate to see why his pattern is different. It might turn out there is a good reason, and, of course, it might not.

Senator RIBICOFF. When did you start the printouts?

Mr. WHITE. Every quarter.

Senator RIBICOFF. How long have you been operating with a printout, how many years?

Mr. WHITE. This started out in the first part of 1968.

Senator RIBICOFF. You ran for 3 years?

Mr. WHITE. We used the new computer system.

Senator RIBICOFF. You ran for 3 years where there was no printout?

Mr. WHITE. No, we had a different kind of printout at that time. The kind I am talking about is the new one put in, and prior to that time we did it externally, outside of the computer, manually, and we have gone to the computer program.

Senator RIBICOFF. Suppose you found Dr. Brown was running a pattern absolutely inconsistent with other doctors. What did you do about Dr. Brown? Tell the committee, where all of a sudden you see a pattern of large billings for large amounts in the same period of the day, same period of the month. What do you then do to check on Dr. Brown?

Mr. WHITE. First of all, as I said, pull out all claims for the period—individual claims. In some cases, depending on the kind of claims they are, we will go back and get hospital records on the particular claims to get them more detailed than we have on the claim itself.

In some situations we may send a professional relations man out to talk to the doctor, to see what kind of pattern or practice he has. Some of these situations we have where, because of talking to the doctor, he has changed his billing methods, or we negotiated and said, "Doctor, you are making three or four visits a week to this patient, and we are only going to pay for one, and we are not going to tell you how to practice, but we will only pay for one a week."

There are many kinds of situations we encounter, and we have to negotiate and make decisions on what we think is a reasonable payment.

Senator RIBICOFF. So you have had a number of these circumstances where you think the doctor has been out of line. So what do you do when the doctor has been out of line you feel required to report it to the local, whether it is local, county, or State, medical society? How do you handle this? When do you make the decision to report it?

Mr. WHITE. Actually, that is a byproduct of what I said we did.

Where we feel we can't do anything by dealing directly with him, we will report to the county medical society for their consideration.

In a few cases, actually there have only been a few, were suspected of fraud, and, of course, we refer those to the Government. There has not been many of those.

Senator RIBICOFF. What has the county medical society done, when they have gotten a complaint from you? Do you know of any cases?

Mr. WHITE. Yes. I think, and I would have to say I can't give you the figures, but most of the cases they agree with us. We might find a doctor it appears the billings he submitted do involve overutilization, and it usually has an effect on the future billings.

Senator RIBICOFF. Now, when we get to utilization in the hospitals, overutilization, and in the question of the utilization review committee, do you find this is not working, either?

Mr. WHITE. I think that the utilization review committees in hospitals, well, some places they work better than others, but I think the utilization review committees in hospitals are doing a fair job. I wouldn't say a good or excellent job at this time.

Senator RIBICOFF. You see, here is something else. The committee, when setting this up, was trying to be as conservative as possible and interfere as little as possible with the practice of medicine. You and the Blues said, "We don't want the bureaucrats telling the hospitals how long somebody should stay," so we let the doctors and boards supervise themselves and police themselves, and we wake up now and find they have not been policing themselves.

And you have a situation or pattern throughout the country where you have many hospitals where the occupancy rate is low, people stay 3 or 4 days, and where the occupancy rate is high, the length of the visits are curtailed.

Now, again, how you do this? How do we maintain private practice of medicine? How do we keep the hospitals running on a private basis, without Government interference? How do we allow carriers to remain in as intermediaries? How do we do this and at the same time make sure the social security funds, the medicare funds, parts A and B, are being run soundly, and are not being wasted?

How do we do it, from your experience in the program, and as a private insurer? What can we do?

Mr. WHITE. I think there is one thing I should mention, Senator. A lot of the figures in the staff report are not 1970 figures.

I can assure you that, as time goes on, we are all getting more experience in handling it, and we are cutting more and more as we go along, and it outweighs the scope of these problems.

For example, today we are, in effect, and this is causing a problem, overruling the utilization review committee, and actually denying claims approved by the utilization review committees.

Believe me, this causes real problems, because, again, everyone thinks he is entitled to the benefit, and then, when we cut it off, the patient's relatives particularly give us considerable trouble about the fact, "My mother is entitled, and you have no right to cut it."

Senator RIBICOFF. I had more questions, and I didn't want to take up all of the time, but I will come back after Senator Williams asks his questions.

Senator WILLIAMS. I will only take a couple of minutes.

How do you get paid by the Government for handling the medicare and medicaid programs?

Mr. WHITE. We are reimbursed our administrative costs. It is a "not for profit, not for loss" contract.

Senator WILLIAMS. Is it a cost or cost-plus basis, or based upon the amount of claims handled?

Mr. WHITE. It is "not for profit, not for loss" basis. Actually, reimbursement of the expenses we pay to pay the clerks and for the computer, and so forth.

Senator WILLIAMS. You mean you handle it for nothing, no profit?

Mr. WHITE. That is right, unfortunately.

Senator WILLIAMS. Prior to the initiation of the medicare and medicaid programs, your company sold a general broad health insurance plan, did they not?

Mr. WHITE. Yes.

Senator WILLIAMS. Where families and individuals could buy it?

Mr. WHITE. Yes.

Senator WILLIAMS. At any age, 20, 30, or 40 years of age, and they could carry it through life. Is that correct?

Mr. WHITE. Yes.

Senator WILLIAMS. What was the average cost, approximately, for that?

Mr. WHITE. Yes, Senator, I will tell you, we had a rate manual about that thick of all rates, and I couldn't tell you right offhand. I could get the figures for you.

Senator WILLIAMS. Now, as this individual approaches the age of 65, you kept right on insuring him—right on through—or did you cancel?

Mr. WHITE. Prior to medicare, we had policies guaranteed renewable for life.

Senator WILLIAMS. Right on through life.

On your loss ratio, or payments for medical claims, how would it vary there? Would a substantial part of the payment of the claims develop after the age of 65, or before?

Mr. WHITE. After. Actually, of course, utilization went up with age, so on the guaranteed renewable premium we had to build up a reserve in the beginning to help pay the claims when people were older.

Senator WILLIAMS. It was taken into consideration across the board? You did not increase the premium when he reached 65?

Mr. WHITE. No, we had a constant premium guaranteed renewable for life.

Senator WILLIAMS. When medicare moved in, did you mesh the medicare benefits with your insurance program?

Mr. WHITE. We write policies now which fill in the gaps for medicare, rather than the full scope of benefits as we did before.

Senator WILLIAMS. How do you handle the policies that were in existence before?

Mr. WHITE. Pardon?

Senator WILLIAMS. How do you handle policies that were issued before medicare came in, and where the policyholder takes medicare?

Mr. WHITE. We couldn't cancel the policies, because they were guaranteed renewable, but most people canceled. They had the policy right to cancel, so there are very, very few left in existence, but most, when medicare came along, dropped.

Senator WILLIAMS. Those that did not drop, how do you handle the payments?

Mr. WHITE. We still have to pay them, if they submit claims, whatever the benefits are in the policy.

Senator WILLIAMS. You pay them on the policy, and they collect medicare at the same time? They collect both?

Mr. WHITE. Right, but there are very, very few of those left, and we don't sell them any more.

Senator WILLIAMS. Well, that was the next question.

You force a person over 65 to come in on medicare in order to get supplemental insurance. Is that correct, or do you sell that insurance?

Mr. WHITE. We don't sell over-65 now.

Senator WILLIAMS. That is what I mean. You don't sell any at all?

Mr. WHITE. No. Some companies sell supplemental coverage to individuals over 65. In other words, they will pick up extra hospital days or drugs or things deductible, not covered under medicare. It so happens we don't.

Senator WILLIAMS. You are pretty well forcing those in that age bracket over into the medicare program. Is that correct?

Mr. WHITE. We have always been concerned, not always, but for a good many years, about duplication of coverage and effect on utilization. That is one of the reasons we didn't want to duplicate the medicare, because the people are entitled to that benefit.

Senator WILLIAMS. I understand that, but I was wondering, in the event someone was not covered with medicare, you have no insurance program for them right now?

Mr. WHITE. There are some companies that write it. My company does not. We happened to choose not to, because we felt volume would be small. We write supplemental coverage in groups, where the people are still working after age 65.

Senator WILLIAMS. The reason I asked is that there have been suggestions made there is a blank spot here for those below 65 now. You hear talk about a national health insurance program, and I wonder what the effect would be if you had a program such as that. Would it force you out of business, or would you be willing to go out of business?

Mr. WHITE. Certainly, if there was such a program, it would put us out of business.

Senator WILLIAMS. I know it would, but I wondered if it was being pushed in that direction. That is the point I make.

Mr. WHITE. Certainly, below 65, if there is no national health insurance program, today, we are aggressively selling private health insurance, all we can.

Senator WILLIAMS. I understand that. I just wondered how long we would go in a situation where you have a Federal health insurance program, national health insurance program, for the high-cost risks over 65 and the coverage running up to that age in private industry, and then turn over the insurance to the Government because the best part of the insurance business is when they are younger.

Mr. WHITE. Yes. Although I must say we have had good experience in our over-65 business, and my particular experience, and I don't know of other companies, but we have had good experience with people over 65.

Senator WILLIAMS. And your experience, if it was good, why would you cancel it?

Mr. WHITE. It was not canceled. People dropped it.

Senator WILLIAMS. You are not issuing it any more, I mean.

Mr. WHITE. Because we didn't want to duplicate medicare business, and there are so little markets left. It is our feeling if you try to sell too much duplication of benefits it aggravates the problem we were talking about, of overutilization.

Senator WILLIAMS. I agree with you on duplication of benefits.

Mr. WHITE. I think about 96 percent of the people took part B, so it pretty well took the market away.

Senator WILLIAMS. In view of the fact that we have several witnesses, that is all I have.

Senator CURTIS. I am not a member of the subcommittee, but I might ask this question.

Isn't it true that about 11 percent or less of expenditures for medicare and medicaid go to doctors?

Mr. WHITE. I think the figure is something like that. I wouldn't have the figure before me.

Senator CURTIS. About 10 or 11 percent?

Mr. WHITE. I know a small part. Institutional benefits cost the most money.

I am not sure of the exact figures.

Senator CURTIS. I don't want to put words in your mouth, but I didn't understand your colloquy with Chairman Long.

You were not endorsing the program of group practice of medicine, were you?

Mr. WHITE. I am saying certainly that is one way of providing health care, and there are some situations like that in existence, and some of them are very good, that I know of, but I was saying you don't always have that type of situation available to people throughout the country. Even if people wanted it, it is just not there.

Senator CURTIS. We have about 20 million people in the United States over 65 as far as hospital benefits are concerned in hospitals; in all likelihood 19 million of those have not paid anything for it.

The 20 million people over 65 that are alive, perhaps about a million or less may have paid something in 1968 and 1969, and if they paid for I year, they paid $46.80. I am quite disturbed over the fact of the tendency to blame everybody for the fate of medicare.

Articles are written, speeches are made, some in Congress and some out, which blame the doctors, which blame the insurance companies for failures of medicare. Great tirades are made against the hospitals, against the way extended-care nursing homes are run, and there is another body of criticism directed against actuaries. I can hardly think of anybody that has not been blamed.

This brings to my mind a statement I read many years ago, that no man is a failure until he commences to blame his in-laws for all of the problems he has in life.

It might just be that the problem is with the law, the medicare law. I regret the inference which is going out from Washington that we had a good, workable, sound, reasonable law, and the insurance companies and hospitals and doctors and actuaries all were greedy and messed it up.

Now, wouldn't one way to cut the cost of medicare be if we stopped paying bills of wealthy people? They are able to pay their own medical bills. Would that cut the cost?

Mr. WHITE. Well, I am certain it would cut the cost if you eliminated a certain group of people, but I don't really know how many people are in that category over 65, so I don't know how much it would cut cost.

Obviously, if you cut out a group, it will save money, but I don't know how many people are involved.

Senator CURTIS. The young fellow that is supporting a family, who is maybe 30 years of age, is paying six-tenths of 1 percent of the medicare cost now, and there is talk about raising it to 1 percent on a base of $9,000.

Such a young man has to pay his own medical and hospital insurance, he has to go out into an inflated medical market, which has been agitated and made worse by medicare, to pay his own medical expenses in addition to all of these other burdens, his life insurance, maybe paying for his education, maybe buying his home, he is required to support a program that in reality is more or less a welfare program.

It seems to me that if we really want to cut the cost of medicare there is one practical way of doing it, which is eliminating certain payments. If this goes on like it has for the last several months, with everybody blaming everybody else, that does not arrest the cost.

Mr. WHITE. Certainly it is within the power of Congress to modify the law. In fact, in the statement we didn't make this recommendation, but we made recommendations of changes in the law to help improve the program.

I think that with the experience, with experience you find out deficiencies or defects in the law. When you first write a law, you don't know how it is going to work, and now it has been tried, I think there are areas within the law that could be changed to improve the program.

Senator CURTIS. Sir, there is deductible at the time of enactment in part A, I think, $50, and part B it is $40.

Mr. WHITE. The other way around, $40 originally in part A, and $50 in part B.

Senator CURTIS. I turned them around.

I offered an amendment on the Senate floor that the deductible be those figures, or the amount of income tax the individual paid in the year previous, whichever is greater. It could be easily administered.

Someone goes to the hospital, and he is asked the question: "Did you file an income tax return last year?" And if the answer is "No," then their deductible would be the amount in the law. If they filed one, and paid $2,000 in income tax, their deductible would be $2,000. If they paid $500 income tax, it would be the $500.

We lacked some 12 or 15 or maybe 20 votes to pass it.

Do you see any real hope, without changes in the law, of lowering the cost of services being rendered now?

Mr. WHITE. No, I really don't. You can change the law, and put some limits, for example, in the program. But one of the problems which I mentioned a while ago is the fact that, if you put arbitrary limits in, you may end up leaving the older person holding the bag.

Senator CURTIS. What do you mean by "arbitrary"?

Mr. WHITE. If you put in a price schedule for physicians' charges, saying "this is the benefit to be paid," and physicians' charges continue to go up, the elderly person has to pay the difference between what the fee schedule provides and the doctor's actual charge.

Senator CURTIS. Up until the advent of medicare, that was the way you wrote most of your insurance, wasn't it?

Mr. WHITE. On a schedule basis?

Senator CURTIS. Yes.

Mr. WHITE. Actually, the sale of major medical insurance was not generally on a schedule basis.

It started quite a long time before medicare, and in fact has been our big product saleswise for many, many years. We did have contracts with various schedules, and you as a policyholder had your choice. If you want to pay a certain amount per month, you would get a certain schedule, and if you paid more, you would get a higher schedule. You could pick and choose how much money you wanted to spend for a certain amount of protection you might want.

In that situation, of course, again, you are talking about employed people, and they make a decision about what their earnings might be, and they can afford to pay.

Most of the elderly people are retired.

Senator CURTIS. Yes, but many people over 65 are better off financially than they have ever been in their life. A lot are not, and must have help, of course, but some are no longer educating their children, they are in the lower tax brackets, and their homes are paid for. I am thinking of the burden that we are putting on all of these young people.

You hear such unusual remedies suggested. I heard one person in all sincerity say, "These hospital costs are getting so high that the Government should take over all hospitals and run them like veterans' hospitals."

Now, that wouldn't lower the cost of it, would it?

Mr. WHITE. No, I don't think so.

Senator CURTIS. It would shift the manner of payment, and who pays it, but it wouldn't lower the cost of operating?

Mr. WHITE. I doubt seriously it would make any difference in the actual cost of operating it if the Government ran it or if a private association ran the hospital.

I think probably the hospitals in either case are faced with rising wages, other increased costs of operation, and whether the Government owns the hospital or someone else.

Senator CURTIS. I should not take so much time of the committee, but I will look with real interest at your specific suggestions.

I had a suggestion forwarded to me from a country doctor which I think is worth consideration. He pointed out for some people that are ready to leave the hospital, from a medical and surgical standpoint they can be dismissed; because their home surroundings are not as pleasant as at the hospital they prefer to stay a few more days in the hospital.

And his practical suggestion was continue to give the hospital care, as we do under medicare, but require the patient to pay for his meals in the hospital. That would be sufficient economic incentive for most of those who beg the doctor and beg the utilization committee to stay longer to leave when it is OK for them to do so.

Maybe it is not workable, but I am always glad when individuals do send in specific suggestions.

Mr. WHITE. Yes, that is a form of coinsurance, paying for meals, or whether you set a dollar amount the person will pay, it is a form

of coinsurance, a theory of coinsurance, which is incentive not to prolong your stay.

Senator RIBICOFF. Would you think we could eliminate the dual payment, where a doctor can charge the medicare fund what is customary and reasonable, and then bill an additional amount on top of that to the patient?

Mr. WHITE. Well, under the structure of the law as an insurance program, and it is an insurance program, you are, in effect, telling the beneficiary "we are going to provide insurance against your cost of care." There is no real direct relationship with the doctor, so it calls for a restructuring of the law.

Senator RIBICOFF. Would you recommend such a restructuring?

Mr. WHITE. Well, we have not really considered that in our committee in our discussions, at all.

Senator RIBICOFF. In other words, don't you think the average patient is rather surprised the first time he goes to the doctor, in assuming the medicare fund will pay his doctor bills, and then suddenly gets an additional bill from the doctor? Don't you think it comes as a shock?

Mr. WHITE. I expect it does, to some patients, because a lot of people, as I said earlier in my statement, have the feeling that medicare pays for everything in full, and in fact it was not intended to, as I understand the law.

As I said in my statement, we need more education about what the program really is to help people, that it does not pay for everything.

Senator RIBICOFF. Mr. Patterson, does your company lend money to the intermediaries under your supervision, either by mortgage or direct loan?

Mr. PATTERSON. No, sir.

Senator RIBICOFF. Your company does not?

Mr. PATTERSON. No, sir. Mutual of Omaha does not make mortgage loans.

Senator RIBICOFF. Senator Williams and I were chatting for a second, and wondering, if you don't make any money, do you want to stay in this business, or get out of it?

Mr. WHITE. Well, I can speak for my company on this one, because I know our company policy, and I know that my president feels that since the law does provide for use of carriers, and we are a mutual company, and rather a large one, almost like a public institution, it is desirable, in effect, to have a partnership with the Government in a project of this kind.

Senator RIBICOFF. Do you think it is fair for the Government to use private industry without compensating them reasonably for their services?

Mr. WHITE. Well, certainly I think that probably there should be some provision for payment, for management, profit, whatever you want to call it, over and above the actual cost of operation. As a matter of fact, this in some way could be geared to performance, and it would be an incentive.

Senator RIBICOFF. In other words, maybe we ought to have an incentive system for the carriers?

Mr. WHITE. Yes; I believe in incentives all the way around.

Senator RIBICOFF. What thought does your group have for an incentive reimbursement to you, where you can make more money for being more efficient and more effective in doing a better job for the fund?

Mr. WHITE. I have to be frank in telling you we have been struggling with it for a long time, trying to come up with a workable formula.

It is very difficult to measure performance. For example, taking one factor: "How many bills did you reduce, for example, doctor bills, as a criterion of performance?"

This wouldn't take into consideration situations where you went out and negotiated fees with the doctor. You would no longer be cutting his fee. You would negotiate a lower fee, that would no longer show up.

By reason of working it, and taking all factors that you might measure on performance, we have not found a good formula, but are still working on it, because we believe it is probably a good idea. If we could develop some reasonable way of measuring performance, rewarding the ones who perform better than others, and perhaps a punitive measure for those not performing.

Of course, there is the other punitive measure, of canceling the contract.

Senator RIBICOFF. Personally, I feel uncomfortable at the thought of you doing this and not being compensated. I think everybody is worthy of his hire, and so is the insurance company.

I would want you to do a good job, an effective and efficient job, a job a lot better than you are doing, but personally, I don't think you should do it for nothing.

Senator WILLIAMS. How many States do you represent?

Mr. WHITE. Prudential in three.

Senator WILLIAMS. You started out with one?

Mr. WHITE. Yes.

Senator WILLIAMS. Did the Government ask you to expand to get two more, or did you seek it?

Mr. WHITE. They asked us, and we accepted.

Senator WILLIAMS. You took them as public-spirited ventures?

Mr. WHITE. Yes.

Senator WILLIAMS. Is that pretty much true with all of the companies that are working on this?

Mr. WHITE. The companies on my committee, 13 companies, yes; it is true. I can only speak for those.

Senator WILLIAMS. It is wonderful there are so many public-spirited people, but I wonder if it is fair for the Government to infringe upon them. If the Government or somebody devised a scheme to relieve you of all of this—relieve you of this responsibility which you are performing for nothing—it is my understanding there would be no objection to it. You are willing to do this work from a public-spirited standpoint, but you would feel relieved to be relieved of all of this responsibility, and all of the other companies would, too. Is that correct?

Mr. WHITE. I don't believe that is right.

Senator WILLIAMS. Since there is no profit motive here, and recognizing the profit motive in industry, I was in business, too, before,

and profit is an important part of industry, and a part of our system, and it is the only case I have ever found where the Government is doing business with somebody where they are not making money, and they want to stay in.

In the defense business, we talk about big profits. Do you think if we turned it over to nonprofit business, you think we would have everyone wanting to work with the Government?

I am amazed at the tremendous outpouring of public spirit.

Mr. WHITE. I will tell you one thing. We have been nonprofit. My company is a mutual company, anyway, but in the health business for many years, even in the present health insurance, we are lucky if we break even, but also I think we firmly believe that any idea of having a private industry, our industry, involved, rather than have the Government operate directly, we believe in that.

Senator WILLIAMS. I am surprised at it, without making money.

On these expensive computers, by doing it for nothing, you can allocate a substantial part of this cost to the Government as part of the overhead cost. Is that true?

Mr. WHITE. It depends on the individual company, whether they have one computer and share it within their own business, but it happens in our business we have a computer just on medicare because of the volume.

Senator WILLIAMS. I won't pursue this point, but I would just assume, based on the normal experience in the business, that if the Government did decide to relieve you of all of this work you are doing from a patriotic standpoint, I don't guess there would be too much objection.

Mr. WHITE. Except for the one point. We still believe it is better to be in the business at nonprofit, rather than to have the Governments do it directly. Philosophically, our company believes that.

Senator WILLIAMS. I do, too, but I am intrigued about the nonprofit aspect because of people clamoring all of the time for the opportunity to do business for nothing. It is just a new experience.

Mr. WHITE. At the time of passage, we were trying to change that particular clause, but we were not successful.

Senator RIBICOFF. We would appreciate, if it was not an imposition on our part, to get as many witnesses as we can, and there may be some further questions that the members of the staff would like to ask. Would it be an imposition for you to remain?

Mr. WHITE. I do have a meeting later in the afternoon.

Senator RIBICOFF. Well, if you have to go, you should.

Mr. WHITE. But the other gentlemen will be here.

Senator RIBICOFF. Let's proceed with the other witnesses.

(The following letter was subsequently received by Senator Anderson and ordered to be made a part of the printed record at this point:)

MUTUAL OF OMAHA,
Omaha, Nebr., April 23, 1970.

Senator CLINTON P. ANDERSON,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR ANDERSON: On April 14 I appeared as one of the witnesses for the Health Insurance Association of America before the Senate Finance Subcommittee on Medicare-Medicaid.

I have just had the opportunity to review the Blue Cross Association statement presented to the Subcomuittee on the following day, April 15. I refer to page 5 of the Blue Cross Association statement referring to administrative costs (copy attached) which is somewhat misleading: (1) The Blue Cross Association is the contractor for more than 90% of the hospital beds in the country, (2) their workload is very heavily weighted with hospital claims as compared to other types of claims, e.g., extended care claims, (3) there are many more hospital claims than extended care claims since only 1 of every 12 Medicare patients hospitalized goes into an ECF. Hospital claims have been getting comparatively little investigation and development by medical, paramedical and experienced claims personnel.

With respect to the companies referred to as A, B and C the reverse is true in that about 85 to 90% of the bills paid are from extended care facilities as opposed to hospitals. The ECF bills require extensive development by highly trained (therefore expensive) personnel because of the widespread misunderstanding as to what is really covered by the extended care benefit and what is not covered. Therefore, the cost of administration per bill is much higher for ECF bills. As you would expect, the development and investigation of ECF bills, though expensive, has saved the Medicare Program and the taxpayers huge sums of money.

With reference to the third column of the attached, the average cost to the Program per day for the extended care benefit is about ⅓ to ½ the cost per day of hospital care so that when you compare the ratio of administrative expense to benefits paid the figure for private companies was considerably higher.

In summary, there are many more hospital bills than extended care bills and when an intermediary processes 85–90% ECF bills as opposed to 85–90% hospital bills, and must necessarily spend more in administrative costs to do a proper job, the cost per bill and ratio of administrative expenses to benefit payments are badly distorted and in need of explanation.

I would very much appreciate it if you would have this clarifying information inserted in the record of the Hearings at the appropriate place.

Thank you for the courtesies extended to the witnesses representing the Health Insurance Association of America by the members of the Subcommittee and Staff.

Sincerely,

B. H. Patterson,
Vice President, Health Insurance Benefits.

JULY–SEPTEMBER 1969 [1]

	Administrative expenses/bill	Bills processed	Ratio of administrative expenses to benefit payments (percent)
Blue Cross (All Blue Cross plans)	$3.67	3,509,861	1.22
High plan	5.68	3,373	1.95
Low plan	1.90	18,394	0.63
Company A (14 offices)	5.73	97,598	1.59
High office	9.90	416	4.52
Low office	4.76	1,183	1.04
Company B (23 offices)	5.32	69,428	2.05
High office	6.08	1,715	3.16
Low office	4.22	23	1.61
Company C (9 offices)	5.13	76,647	1.31
High office	7.64	12,093	2.75
Low office	3.63	1,884	0.87

The role of the Blue Cross Association, in coordinating and administering the work of the Nation's Blue Cross plans under medicare, is not new to BCA. For many years BCA has served the plans, coordinating resources, providing national uniformity for a system with decentralized administration, insuring discipline through conditions of membership, coordinating leadership, and centralized technical skills, thereby avoiding widespread duplication.

[1] Source: SSA memorandum to all part A intermediaries on selected workloads and cost data Dec. 23, 1969.

Senator Ribicoff. Dr. Melcher, please come forward.

STATEMENT OF GEORGE W. MELCHER, M.D., GROUP HEALTH INSURANCE, INC., NEW YORK

Dr. MELCHER. Mr. Chairman, I have three particular points I would like to make in my statement.

The first is I would like to say a little about the organization for which I work, and then talk about utilization control, and then the whole problem of usual and customary fees.

Group Health Insurance, a company with which I happen to be an executive officer, is the oldest nonprofit health insurance carrier in the northeast. It covers approximately 1½-million subscribers, primarily throughout New York State, these people primarily being in the metropolitan area.

In addition, this organization serves as the administrative agency for Group Health Dental Insurance, a nonprofit dental insurer, which covers approximately 400,000 subscribers, and also is the management agency for Group Health Insurance of New Jersey, a small nonprofit carrier.

Furthermore, the oganization acts as a part B carrier for Queen's County in New York, representing about 1 percent of the total medicare volume, that is, nationally.

The major portion of health insurance underwritten by Group Health Insurance is of a comprehensive nature. This organization began many years ago in the area of insuring out-of-hospital services. It began after considerable experimentation in the early 1950's, realizing that the major need, at least the people who ran it thought the major need was for consideration of coverage of out-of-hospital services. For the average income earner and the modest low income person, out-of-hospital physician services represented a much greater potential financial drain than in-hospital services costs.

Over the years, after considerable experimentation, it was found that the public wanted comprehensive coverage. Now, approximately 95 percent of all contracts written by Group Health Insurance include comprehensive out-of-hospital services. This includes physician services, X-rays, laboratory, and preventive services.

The program includes some 10,000 participating physicians. Physicians who have agreed under circumstances of their contracts with us, to accept a fee schedule for covered services, and there is no income limitation. For covered services the plan's payment is payment in full.

Senator RIBICOFF. Would you mind if we interrupt, Doctor?

When you started this set-fee schedule, did you have difficulty with the doctors accepting your fee schedules?

Dr. MELCHER. We have always had a fixed-fee schedule, and certainly—many physicians feel the fees are too low, and do not agree to participate.

Over the years, we had a consistent level of participation of physicians of approximately 10,000 to 11,000.

Senator RIBICOFF. In other words, you felt while some doctors stay out, you don't find you lack doctors to take care of the people in your group?

Dr. MELCHER. That is right. We do not lack physicians, and the patient is perfectly free to go to a physician outside of the program. We reimburse the patient, then. Otherwise, if they go to a physician

and it is a service case, as we call it, or paid-in-full case, the payment goes directly to the doctor. Otherwise, we pay the patient.

I might say the dental program has participating dentists, some 5,000 in the metropolitan area, joining this plan.

Senator RIBICOFF. You talk about metropolitan area. Is that Westchester, Long Island?

Dr. MELCHER. Metropolitan New York area, though we extend and write coverage all over New York State, large groups in Watertown, Painted Post, and so forth.

The major bulk is in lower parts of the State and northern New Jersey.

The combined business of the three organizations handles around 60,000 claims a week in Group Health and Group Health Dental Insurance, and approximately 10,000 claims a week for medicare.

Now, prior to 1966, at which time medicare came into being, I think probably our organization had as much or more experience in handling out-of-hospital claims than anyone in the country.

I might say there is quite a difference in paying and examining claims where one has frequent small claims; and this is out-of-hospital coverage. It is quite different from major medical, though major medical coverages certainly may have many small claims come into it.

We found in 1955, when we first moved into this area, that one of the most essential features in having a program which provides unlimited and comprehensive services is a proper program for examination of the physicians' practices.

If left alone, this particular program, and previous experience has shown this, if left alone with no attempts at examination of his practice, the utilization goes consistently upward.

Now, we found that both prepayment and postpayment audits are essential if you are going to have any adequate control on utilization. Involvement is not only utilization control but examination of good medical practice; not infrequently poor practice and overutilization run together.

Senator RIBICOFF. You say "poor practice and overutilization run together?"

Dr. MELCHER. Not infrequently, they run together. Sometimes they don't.

We place strong emphasis over the 17 years, from 1955 until the present, on development of utilization control programs in our basic business.

I might say during this time, and until this past year, there has been no overall increase in our claim payment ratio. That is, the utilization of physician services has not increased over the years.

When we started this program in 1955, most people said that we would be broke within a year. Well, it did not happen that way. We feel strongly that the major reason we have not is because of the extensive efforts that we put on utilization.

In the medicare operation, we have tried to bring about exactly the same kind of utilization control that we have in our own operation. It is a bit more difficult. Though with the efforts of the Queen's County Medical Society, in the particular county we happen to operate in, we have been able to set up a professional practices committee that

actively meets with the representatives of the carrier, to review and go over certain types of practices.

They have been exceedingly helpful to us, and it has been our feeling that the major good of this has been a physician education program where the physicians are able to see the kinds of practices that perhaps are not in the best interests of both patients and organized medicine.

I feel very strongly that any program which provides unlimited home and office coverage, and in essence that is what medicare does, must have a very active utilization review or control program as a part of its basic makeup.

I might add one other point here, which is not in the statement, that most of us in the insurance industry operate on what we call retention, or cost of doing business.

For example, I sell a contract with a company or with a union, and we assume it is worth $100,000 a year in premiums. I have a 10-percent retention. That means I get $10,000 out of that $100,000 to operate it.

And let's assume that I pay every claim that comes in, and spend $100,000, I then get my $10,000. Then let's assume that in another instance I institute a very vigorous utilization control program, looking at quality of care as well as many other features, and instead of paying out in cash claims $100,000, I only pay $90,000. It costs additional money to do this, and now I only get $9,000. I don't even make the $10,000. So I had to spend more money, and get less administrative cost.

It is much easier to pay claims, particularly when it is done on this basis, than it is to try to control costs.

Our organization feels very strongly, and continues to feel this way, that if we have nothing more to do than to serve as a conduit for money, that is, collecting it from the purchaser and giving it away, if we don't have any more to do than that, we should not be in business. Our board of directors feels that we must involve ourselves in more than just disbursing money, and a good utilization control program is essential to any insurance program that involves out-of-hospital coverage.

I will leave the in-hospital part aside.

Now, I would like to say a few words about usual and customary fees.

I think myself this is one of the major problems in controlling costs. If one examines the record since the early 1950's, on major medical insurance and other programs of this nature, it seems clear that the cost of such programs is one of continued increase in premium.

I think the most serious drawback at this particular time in relation to the medicare program, in addition to the fact that it is impossible, I think, of sound and safe actuarial basis to continue in this fashion on usual and customary fees, is the fact that the patient does not have an opportunity to know, when he goes to a physician, or to select a physician, where he can receive a paid-in-full benefit.

He has no way of knowing when he goes to the doctor whether the doctor is going to accept the assignment or to limit his fee in any way. It is bad enough with employed people, but here we have taken another group, who for the most part have passed their employment, and have

given them an insurance program far richer than most of the working public is able to afford. Then we give them no opportunity to know if the physician will even agree to limit his fees.

We have had a roster of participating doctors for many years, 10,000, approximately, actively practicing physicians in the metropolitan area who have agreed to limit fees. The patients know who they are. Not infrequently this does affect a patient's selection of a physician.

Senator Ribicoff. In other words, you don't have a dual system. When one person insured by your group goes to a doctor, and he gets whatever service there is, whatever your fee schedule may be is the final payment to that doctor. He does not bill the patient an additional sum?

Dr. Melcher. For covered services, yes. In our own program approximately 60-odd percent of services are paid-in-full benefits.

The patient—and not every patient selects a doctor for financial reasons, but there are many instances where this is essential.

It is my strong feeling at this particular point in time, it might be very wise to consider the use of a fee schedule approach, at least until some of the inflationary aspects of health care can be resolved, or until the opportunity presents itself to review some of the problems with the present structure for delivery of health care.

Another area which is producing major problems, and if you will recall, I said earlier in my statement we had no increase, in actuarial experience or payment of cash claims, until this past year. In the New York metropolitan area we have had a large exposure to preventive health examination programs.

There are many organizations that have set out to carry out so-called preventive screening programs. We have been paying such claims since about 1959, so we have a little over 10 years' experience.

In the past 1½ years, we have seen a tremendous increase in claims for such services: so within the year we expect approximately an 8-percent increase in claims cost, as a result of the utilization of these examinations.

This is going to be an exceedingly costly adventure, and I might say that we see very strong indications that nationally the same thing is going to happen, with many organizations setting up screening centers, and many individuals, institutions, commercial organizations, and others getting in the act. I think at some point one must address one's self, in the medicare program, as well, to exactly what you are going to do about this, because you certainly do provide, or will provide, a major open-ended expenditure of many billions of dollars if it goes the way countrywide I suspect it will.

Another serious problem that we see is concerned with the abuse of X-ray and laboratory services.

Unfortunately, the impression was given to medicare beneficiaries that practically everything is covered under the program. Certainly, many providers went to extra measures to carry out services which added to the cost of diagnostic services.

The great abuse of automated lab procedures, where there is no reduction in charges on bills, is a typical example of where a great deal of expenditure is going, and very little increase in benefit to the patient.

One final point not in the prepared statement has to do with teaching hospitals.

I would certainly hope at this point in time you would consider some change in payment, or method of payment, for services rendered in the teaching setting.

It is my strong feeling that this should be under part A, and not under part B.

This has led to serious abuse in many institutions, and I think the only proper solution at this point in time is to put it under part A, on a salaried basis, and on a reasonable basis.

Senator RIBICOFF. Do you also teach at some medical school?

Dr. MELCHER. Yes; Columbia.

Senator RIBICOFF. I was interested in your talk about the overutilization of automated laboratory equipment and X-ray equipment. What is the average cost of such a service?

Dr. MELCHER. Well, that is a good question.

The cost of the provider who is providing, or the charge he is making?

Senator RIBICOFF. The charge to the medicare fund.

Dr. MELCHER. Well, I can't, or I shouldn't say, "I can't answer it," but I can't give you an answer that I think would be correct.

Let us put it this way. In the New York metropolitan area—and I would have to speak to that area at the moment—we first became aware of the so-called automated contract laboratories in the late 1950's.

At that point in time, there was an organization that offered to physicians for some $40, and then later $50, $60, and now I think $100 a month, a service for which the physician could have all of the lab tests he wanted done for that fixed amount of money.

We found very early that a physician would see one patient and order 30 tests; thus recouping his full cost for the month on one patient.

Around the country now there are many organizations that offer automated lab tests, 8-in-1 series, or 12-in-1, for a fixed price, and, unfortunately, most of the time when you get a bill for the medicare patient, or for your own business, you don't know where lab services were performed. They come to the doctor, but we know perfectly well that the average physician cannot do many tests in his own office.

We in our own business know every physician who has a contract. We were able in 1958, with the office of the attorney general in New York and organized medicine, and the contract laboratories, to work out an agreement whereby we would not pay our full schedule allowance for automated tests, but rather a reduced allowance.

I can tell you that there are many, many instances where physicians are using such services and where the full charge is being rendered to medicare, and to commercial companies, and to Group Health Insurance.

Senator RIBICOFF. I would hope the staff would find out from the Social Security Administration whether they have any information as to the total cost to the medicare fund of the automated laboratory services.

Now, apparently you have succeeded where the insurance company and the Blues have failed, in utilization review and control of cost.

Now, what are the elements of your utilization cost-control program, and if you can use them, can't they be used all over the Nation?

Dr. MELCHER. Senator, let me put it a different way to you.

In 1957, we made a decision to become automated, computerized, and that is a long time ago. We made it because, with some help of other people, we were already handling a large volume of claims. For example, a program which is confined to in-hospital services will produce only one-sixth the number of claims as a comprehensive plan.

Senator RIBICOFF. Give me that figure again.

Dr. MELCHER. When you have out-of-hospital comprehensive coverage, you pay many more claims, because there are small frequent claims, doctor's visits, and lab studies. Most of the coverage that was available prior to 1966 did not include comprehensive out-of-hospital coverage, and thus had a much lower volume of claims.

So we decided in 1957 that to handle the mass of paperwork, we would go into electronic data processing. We were getting the concept and starting as early as 1957 in computerizing claim payments, so that by 1963 we had the major part of our program computerized. We still have not gotten everything done the way we would like to see. I might say, to develop a program to pay claims on a real computerized basis in a short period of time is very difficult.

Now, every claim we handle, has to have a four-digit procedure code, and a four-digit diagnosis code on it. These are the very basic elements of trying to control utilization. You have to have adequate data going into the system in order to know what kind of doctor is carrying out what kind of practice on what kind of patient. You then build into it the appropriate mechanisms to bring the claim out for examination, if predetermined limits of service are exceeded.

Senator RIBICOFF. Now, concerning the medicare claims that you handled in your area—are there dual payments there, or do the doctors who operate under the medicare portion of your supervision—are they paid on the same basis as your own group health insurance program?

Dr. MELCHER. You mean paid at the same level?

Senator RIBICOFF. Yes.

Dr. MELCHER. It is not the same.

Senator RIBICOFF. It is not the same?

Dr. MELCHER. I should not say that. Some things are the same, and some are not. Lab services for the most part are the same. Some other aspects, they are different.

Senator RIBICOFF. Are the same doctors who are treating medicare patients receiving more than the same doctor who handles regular patients?

Dr. MELCHER. I would say for the most part they are.

Senator RIBICOFF. Why is that? Why does Dr. Jones charge a medicare patient, say for the same services, more than he charges your group health insurance patient?

Dr. MELCHER. I think it is fair to say that the participating doctors, the ones participating in our program, do not charge more, to my knowledge, than medicare. The ones who are not participating are free to charge anything they want to charge.

Senator RIBICOFF. And they do?

Dr. MELCHER. And they do.

Now, we have reflected that in setting up our prevailing fees. Charges made by physicians in our own program are included in the makeup of the prevailing aspect of the usual, and customary, and reasonable charge determination so it is reflected in the overall payment rate.

Senator WILLIAMS. I will only ask one question, in view of the fact that we have other witnesses to hear from.

In connection with the teaching hospitals, just how does a medicare beneficiary in a teaching hospital recognize or contract with a supervising physician?

Dr. MELCHER. Well, sir, I can't speak for every hospital in the country, but in New York, I can speak fairly clearly.

I think for the most part there has been absolutely no change in the patient's status between 1966 and 1970 for teaching services. Certainly with the institutions with which I am familiar, as far as supervising physicians is concerned, they are exactly the same as 1966. There is no change there. The patient does not select the doctor. The doctor is assigned. He does what he was doing beforehand, as relates to teaching, whether it is medical students, or interns, or residents, or other people.

The patient frequently does not even know who the attending doctor is.

Senator WILLIAMS. Just how should it work with medicare? Or how does it work, and how should it work?

Dr. MELCHER. Well, we are talking now about payment. At present I think in many institutions physicians are getting payments for services that certainly they render, but by no stretch of the imagination is the relationship with that patient the same as with their own private, personal patient.

That is on a fee-for-service basis, and it may be a reduced fee in many instances, compared to the regular fee, but not greatly different.

I think the way it should work, if they are going to receive payment—and I think teachers should receive payment—is to put it on a salary basis, and this should extend to all patients in the teaching study, not just medicare. I am sure it was not your intention in a teaching hospital that the only people who would have to pay a bill would be medicare people. There are other patients there, as well.

In my own institution, I think it is fair to say, I have to make a guess; now, certainly on the medical services, perhaps 30 percent of the patients are medicare, and they are the only ones from whom we are collecting any fees. We are not collecting any from the other patients.

In medicaid, in New York City, we can't. That is not possible under present regulations. The other patients we have never collected fees from, so the only ones we are collecting from for the in-hospital patient, not the outpatient, are patients covered under title XVIII.

Senator WILLIAMS. Do you think we should stop those payments?

Dr. MELCHER. I think you should, or pay the physicians on a salary basis under part A; that would be my strong recommendation.

Senator WILLIAMS. Would it work if one-third of the patients were under medicare and the other two-thirds private? Would the salary be allocated?

Dr. MELCHER. I think the salary would have to be allocated equal to all, certainly not just to medicare patients.

It is a very serious problem, and certainly in New York State we have had a rather major legal action several years ago in one of our large teaching institutions, where the local Blue Shield plan refused to recognize such payments, or to make such payments. There was an opinion in which the plan was supported because there was no private patient-physician relationship developed between the ward patient who had an assigned physician, so that payment could be made.

In my own company, we do not recognize payments to interns, or residents, or supervisory physician services in a teaching setting. Now, up to this point in time, none of the hospitals have made a legally enforceable charge.

Senator RIBICOFF. One more question. What is the average administrative cost per case that you receive from the medicare fund?

Dr. MELCHER. In the last quarter, 1970, it is approximately $3.60. It may be a few pennies above or below. Our costs have been going down for the past year.

In our own business, we have made major strides in the past 2 years, with a new method of optical scanning and other means, and applying some of the same measures to medicare.

Senator RIBICOFF. I am wondering, if I may ask Mr. White, what is the average cost per case for your group?

Mr. WHITE. I can't give you all three companies.

Senator RIBICOFF. What is yours?

Mr. WHITE. About $3.15.

Senator RIBICOFF. Thank you, Dr. Melcher.

Next is Mr. Parish and Mr. Knebel.

You may proceed, Mr. Parish.

STATEMENTS OF NED F. PARISH AND JAMES D. KNEBEL, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS (CHICAGO), AND JOSEPH C. RHEA, ASSISTANT VICE PRESIDENT OF GOVERNMENT PROGRAMS

Mr. PARISH. Thank you, Mr. Chairman.

My name is Ned F. Parish. I am executive vice president of the National Association of Blue Shield plans.

Thirty-three of our member plans have been serving as carriers for part B of medicare, servicing about 60 percent of the program's beneficiaries.

With me are James D. Knebel, assistant executive vice president of the association, and Joseph C. Rhea, assistant vice president of Government programs. Both of these gentlemen have had extensive involvement with medicare and medicaid, and will be available for any questions the committee may have.

We have studied the report of the committee's staff on medicare and medicaid. We compliment the staff on the thoroughness of its research. We concur with the objective of making these programs as effective and economical as possible. We feel, however, that the conclusion that part B carrier performance has been, in the majority of cases, erratic, inefficient and costly is too general and needs further explanation.

The staff report is based, in large part, on 1968 data. It is true that 1968 data do not reflect a level of carrier performance that we should like to see in a fully matured program. But it is most important to understand that part B of medicare was not in 1968, and is not today, a matured program.

The carrier plans have made a great deal of progress in the 2-year interval. The most recent workload reports—for February, 1970—show a median claims inventory of 3.2 weeks, down from 3.6 weeks for the same month in 1968. Most importantly, this reduction in inventory was achieved despite a 31 percent increase in claims received, amounting to 700,000 more claims in January, 1970 than in January, 1968.

Forty-two percent of all medicare claims received through the end of 1969 were received in 1969. This means that volume was about 50 percent higher in 1969 than could have been expected on the basis of 1966–68 experience. As for this present year, we believe that neither utilization of medicare nor the resultant workload for the carriers has yet stabilized.

The committee should understand exactly what this has meant to Blue Shield. Our plans characteristically have no activity except the financing of medical services. They are not subsidiaries nor divisions of larger entities. Neither have they subdivisions of their own from which they can transfer resources. It has been observed by such impartial agencies as the Columbia University task force on CHAMPUS that this approach gives Blue Shield a superior understanding of medical care programs. But it also means that the impact of change falls directly on, and must be absorbed by, the basic operation.

From 1967 through 1969, the Blue Shield carrier plans' growth in private business, as measured by dollar volume, was 46 percent. Most of this was the result of making available more comprehensive and sophisticated coverage, as Government, among others, has encouraged us to do.

Through the end of 1969, the carrier plans paid $2,624 million in medicare B claims. In the same period, they paid $3,693 million in their private business. Thus, over a 42-month period, medicare represented a 71 percent incremental load on a group of plans already coping with a 46 percent expansion. The increment was neither gradual nor evenly distributed. It hit suddenly, and in some areas overwhelmingly. In a few plans, medicare benefits mounted to as much as 300–400 percent of private business payments.

We are unaware of any national industry—particularly a service industry—which has undergone a comparable experience. Certainly none has done so under comparable public scrutiny. In some plans, staffs had to be doubled or even tripled in a 2-year period. By definition, more than two-thirds of the employees had little or no experience. New supervisory positions were created, and filled of necessity by people with less than usual experience. Many other problems materialized that were the inevitable result of an inadequate supply of trained personnel in an industry that has become successful through the skills of its personnel.

We explain all of this not to apologize for poor performance, but to assert that in the circumstances performance has been remarkably good. There have been deficiencies, and undoubtedly some waste. We very much doubt that they have exceeded reasonable limits for putting

a program of this magnitude into operation literally overnight, and working through a massive shakedown period. There are clear indications that despite the fact that medicare volume continues to rise, nearly all Blue Shield carriers have succeeded in building organizations strong enough to control the program.

The two points of greatest importance in the present development of medicare are generally agreed to be cost containment and administration. Cost containment, in turn, can be influenced primarily through utilization review and methods of physician reimbursement. We believe that of the two, utilization review holds the greater promise, in the long run, for influencing the cost of a given level of benefits under the program.

Review of physicians' utilization involves the finding of intentional abuse, which is relatively simple to detect and relatively insignificant as an expense factor. It also involves determining the proper level and quantity of treatment for patients. which is potentially quite significant in terms of program cost, but extremely difficult to gage objectively. Blue Shield has been exercising initiative to develop greater capacities in this area. By the standards of 1970 we are succeeding. By the standards of 1975, there is some distance to go. Utilization review is still an emerging activity.

Last year, the Blue Shield plans and our association formulated a detailed, effective, and up-to-date program for utilization review. We are just completing an evaluation of Blue Shield activities in the light of this program. We find that the carrier plans are responding well to the needs of the Government's programs and of their private business.

We identify four elements in effective utilization review. They are, first, prevention of poor utilization, done through educational programing directed at physicians and their employees to create consciousness of the need for attention to proper utilization. This attention is by far the most important element in optimum utilization. Second, there is detection, consisting of computer, manual, and special sample review, aimed less at discovering fraudulent practice—although this is certainly an objective—than at identifying patterns that do not conform to normal usage. Unusual patterns frequently show nothing more than unusual caseloads: for example, referral practices very high in certain diagnoses, or very heavy patient loads in areas short of physicians. But often they show areas where corrective action is indicated.

Correction is the third element. It relies on field contact, contact by plan-sponsored committees of the physician's peers, or by similar committees of the local medical society. While it can be and sometimes is aimed at recovering money wrongly paid, it is more usually educational, aimed at making the physician cost-conscious in selecting appropriate means of care.

Finally, there is reporting and accounting of the results of utilization review. This element has only recently been added to the Blue Shield process, and we are still developing it. It has been generally felt that prevention, detection and correction, supported by educational programs, were a complete cycle in themselves. The feeling was reinforced by the knowledge that the existence of an effective utilization review program is a major deterrent to abuse, making true savings

literally incalculable. Recent developments have convinced us that we must indeed measure and evaluate identifiable dollar savings, and this process is under development in most plans which do not already have it.

It is worth repeating that the program the plans are implementing is an excellent program at the moment. We doubt that there is one with comparable capacity in existence. But we are still finding out about utilization review. A full-time staff in our office is charged with accelerating its development, and working with the plans toward continual improvement of the process.

We expect that beneficiary education will emerge as an increasingly important factor in utilization control. This will involve educating both the individual and the community. Patients, and particularly elderly patients such as medicare beneficiaries, can and do exert influence upon the length of their stays in institutions and the frequency of their office visits. It is not entirely realistic to think that discharge criteria are so clear cut that a physician can gage exactly when to discharge an elderly patient who pleads that he needs one more day to feel well enough to care for himself, or until a relative is available to help him. In fact, in the present medical-legal climate, the doctor takes a substantial personal risk if he forces a discharge over the patient's objections. Only if the patient understands and accepts the need for optimum utilization is it likely to be achieved.

Communities must accept the same goal. Unnecessary facilities should not be supported. Home health services and recuperative facilities should be more widely developed. The community without acceptable alternatives to the most expensive care must learn to ask why, and to demand change.

Both Blue Shield and Blue Cross have been attacking the problem of beneficiary education for some time. However, it is not clear that the carrier's authorities are as broad as might be desirable in this area.

CHARGE DETERMINATION

We testified in 1965 that basic coverage, implemented through fee schedules utilizing participating physician contracts and augmented by supplemental coverage, would be a better approach to financing care for the aged than the present medicare system. We said that our test of performance studies showed that the Federal employee program contracts then in effect would be accepted as full payment for professional services in the vast majority of cases. We still believe that that was true. However, 5 years have elapsed. Charges have risen considerably beyond 1965 levels. Few Blue Shield schedules have been modified to take the increase into account, because the groups for whom this would have been done have characteristically moved to reasonable charge coverage. One-third of Blue Shield's private business is now on this basis.

We are frankly unsure that it is possible to revert to fee schedules without sacrificing either the interests of the beneficiaries or the efficiency of the payment. By efficiency, we mean paying no more than the individual case requires, while taking into consideration charge differentials between specialists and generalists, economic areas, types of practice, and other factors. Physicians have become accustomed to

the reasonable charge method and its corollary—one charge to all patients for the same service. If the program undergoes a radical change in payment methods, we foresee either a reversion to dual charges, which say will raise costs to the population under 65, a loss in payment efficiency, or an increase in unmet costs to be paid from the patient's personal resources.

The basic question is what is the program's objective? If it is to indemnify the beneficiary within the absolute limits of a fixed premium, as the committee staff has recommended, this can be done. A fee schedule (or schedules) establishing the program's liability could certainly be worked out. If, on the other hand, the objective is to maintain a predictable relationship between payments and incurred cost, and if the costs of other goods and services continue to rise, it is only realistic to expect that physician's fees will rise too, and to take this into account.

The administration's approach is to retain the customary and prevailing charge elements, but to introduce a timelag by freezing allowable charges for a year at a time. While this illustrates a possible approach to controlling the rate of increase, we do not consider it particularly desirable, in that it may actively induce escalation when changes in customary charges are recognized.

Blue Shield feels strongly that the reasonable charge method is the best means of reimbursement. Our application of this method in private business requires taking into consideration the patterns of charges for similar services provided under comparable circumstances in the same geographic area; evidence of professional support; development and maintenance of individual physicians' charge patterns; and regular professional review and analysis consistent with plan responsibility to both physicians and the general public.

This does not mean that the customary and prevailing charge criteria have to be wholly self-determining. Experiments are being conducted in some plans' private business with methods of stabilizing the rate of increase. They usually rely upon some external index to govern the rate of change, either by individual procedure or through calculation of the impact of a specific change in a specific charge on the physician's total income. While it is early to draw long-term conclusions, both methods do retain the basic efficiencies of reasonable charge reimbursement, and offer the physician some assurance that his payments will keep pace with the general economy. This assurance is very important in encouraging restraint in charges. It develops confidence in the basic equity of the system. While we cannot demonstrate it, we believe that a significant amount of escalation has been triggered by fears on the part of physicians that they will lose their ability to protect themselves in an inflationary economy.

ADMINISTRATION

It has been pointed out that performance has varied considerably between carriers, including carriers who are Blue Shield plans. This is perfectly true. We feel it would have been less true if our 1965 request had been granted, and we had been permitted to work as a system. The decision to contract individually with plans took away the opportunity for some economies and concentrations of resources

that are usually available to Blue Shield in servicing major national accounts.

Usually, a multiple-plan account is serviced through a control-plan arrangement, in which one plan takes responsibility, and directs the activities of other plans who underwrite and service their portion of the account. This approach is supported by review teams from the national associations which conduct onsite inspections to identify areas of weakness and assist in overcoming them.

As a national association, we have attempted to carry this system over to medicare, despite the obvious lack of either control-plan authority or adequate financing, since we are not a contractor with Government. We have given a great deal of technical assistance, including, in one case, a complete transplant of an effective claims processing system to a plan whose existing system was not adequate for medicare's volume and complexity. We have recently sought and been granted by the Blue Shield plans authority to set and maintain standards of performance in the administration of Government programs.

Obviously, SSA is charged with the administration of medicare. Any standards of our own will have to be, and will be, at least as stringent as those of the Bureau of Health Insurance. But we have concluded that Blue Shield will reach its full potential in this program only if we revert to accepting the responsibility collectively. This is in no sense an effort to undermine SSA's authority. It is to do what SSA cannot do—to move the resources within our system into problem areas and to resolve weaknesses in one plan by using the strengths of another. This effort will be complementary to SSA's and will, we are convinced, result in substantially stronger carrier performance than could be achieved in any other way.

Neither we nor, we believe, anyone else accurately foresaw the extent of the demands that medicare would place on the carriers. Most of the plans' effort and our own, up to this point, have been aimed at overcoming immediate problems. We believe that most plans have now reached performance levels which permit us to turn our attention to correcting remaining deficiencies and upgrading service levels.

In discussing levels of service and costs of administration, we think it would be wise to consider whether cost reimbursement alone provides the carriers with adequate incentives to improve service and reduce unit costs as fully as possible.

MEDICAID

Mr. Chairman, for reasons of time I cannot comment at length on medicaid. But we would like to state our basic position on the administration of the program. Like medicare, this program is replete with technical problems. Fundamentally, they are maintenance of eligibility records; determination of proper payment to the provider of services; monitoring utilization, not only to contain costs, but to assure quality; prompt and accurate processing of claims; auditing of provider claims; and developing and reporting information regarding the program so that it can be properly monitored, and an accounting made of public expenditures.

Delivery of these responsibilities requires understanding of and experience in financing health care. In general, these are available

at State level only through carriers, either Blue Shield or commercial. And effective use of carriers hinges upon careful, detailed understanding in advance of the responsibilities of each party to the agreement.

With Blue Cross, we have developed a model carrier contract. This was done as a service to our membership, and was not financed by Government. It was, however, offered to the Department of Health, Education, and Welfare, and was adopted by the Medical Services Administration as the Government's model for title XIX carrier contracts.

We believe that many of medicaid's problems, particularly as compared to medicare's, stem from the program's failure to avail itself on any wide scale of the private sector's abilities as medicare did. Relatively few States used carriers. Blue Shield is involved in 21 States, in some of which it has limited functions even with respect to professional payments. Five additional States are using commercial carriers.

Even in those States using carriers, there is little national coordination. We have worked with our own plans, but even this is difficult because of the variety of local arrangements. Much more could and should be done to buttress medicaid administration through proper use of carriers, and through introducing more common elements into their use.

CONCLUSION

We believe that the administration of medicare is emerging from the crisis stage that it has been in almost from the program's beginning. We feel that the time has come when most Blue Shield carriers can and will turn their attention from coping with day-to-day problems to perfecting their administrative mechanisms. This does not imply that there will be no more operational problems. Almost certainly there will be. We feel that it would be useful to have a more formal system than now exists to bring the resources within the Blue Shield network to bear upon local problems. We are working very actively to develop such a system. We expect that the expertise that has now been developed, together with better mechanisms for applying it, will provide a high level of administrative support for the program.

Mr. Chairman, this concludes our testimony. We appreciate the opportunity to appear before the committee, and we will be glad to attempt to answer any questions you may have.

Senator RIBICOFF. I am curious, sir, who do you represent? Do you represent the providers or the users of the services?

Mr. PARISH. The National Association of Blue Shield Plans represents its member plans. Are you talking about individual Blue Shield Plans?

Senator RIBICOFF. Yes. Who do individual Blue Shields represent?

Mr. PARISH. They represent both the public and provider.

Senator RIBICOFF. The public and provider?

Mr. PARISH. Yes, sir.

Senator RIBICOFF. Now most Blue Shields are offshoots of State medical societies, are they not?

Mr. PARISH. In terms of their origin, the beginning of plans are varied. In some instances, you are quite correct. They were begun in the early days by medical societies who were concerned as public representatives or as citizens of a community that there was a need for this kind of plan.

Other plans originated as offshoots of the beginning Blue Cross Plans and they began in that fashion subsequently approved by the local medical society. There are really two beginnings.

Senator RIBICOFF. But aren't many Blue Shield organizations dominated by doctors on the board of directors?

Mr. PARISH. I would only quarrel, Senator, with the use of the word "dominated."

Senator RIBICOFF. I don't mean dominated, but aren't the boards composed in great many instances by doctors?

Mr. PARISH. On the average across the country it is roughly 60–40, 60 percent physician and 40 percent public representation. It varies by plan.

Senator RIBICOFF. The doctors represent the working majority?

Mr. PARISH. Overall.

Senator RIBICOFF. And some Blues are really agents of medical societies. Aren't there a couple that are really such agents of medical societies?

Mr. PARISH. There are two—I think only two, where the Blue Shield Plan is an adjunct of the State medical association and it is operated out of the same office, but it does have its own separate function.

Senator RIBICOFF. Which States?

Mr. PARISH. Wisconsin and South Dakota.

Senator RIBICOFF. Now the Blues testified before this committee in 1965 "that even in indemnity plan areas Blue Shield schedules generally reflect the prevailing charges in the community and that including service benefit plans an increasing percentage of claims are satisfied in full by the Blue Shield payments."

If that was true, how could Blue Shield service benefit schedules have been generally ignored as a limitation on payments to medicare doctors?

Mr. PARISH. In the first place, Senator, I think the statement that was made at that time, which you have quoted virtually verbatim, has to be considered in the context of what we were talking about at that time, namely, our proposal to this committee recommending the use of prepayment, the Federal employee contract was given as a precise example, with a $7,500 income level.

Our test of performance, which we conducted prior to that time—it was an exhaustive comprehensive study—indicated on the basis of present schedules, that is, the Federal employee program schedules, that in effect we would have this situation.

Senator RIBICOFF. Well, reading further from page 532 of part 1 of the hearings:

> As you know, there is a growing tendency among physicians throughout the country to stabilize their fee schedules and to accept the same fee for similar service from all patients regardless of income.

Now, if this was the case when you people testified back in 1965, why the sudden change? Why shouldn't we have a fixed-fee schedule generally that medicare works out with the carriers and the intermediaries and the medical societies and come up with a fixed-fee schedule?

That is what it is going to be. You say in 1965 physicians were going that way anyway.

Mr. PARISH. In 1965, to get back to this for a moment, our test of performance indicated that under the high level Federal employee program, we were paying a substantial portion of charges incurred.

We estimated, or to continue with the sentence, we said:

With respect to the proposed planned elderly population, it is reasonable to expect that plans throughout the country will be able to provide services on a paid-in-full basis for 80 to 85 percent of the aged patients.

This is talking about what Blue Shield had at that time, a fee schedule approach. The usual customary and reasonable term had not been accepted, and only in a limited sense had it come into the picture.

Senator RIBICOFF. Let me say, since I have gone over the chart, and it is a shocking chart when you consider the Blue Shield maximum payments and what has been paid under medicare—Alabama, let's take a cateract in Alabama is $345 and Blue Shield is $75.

Taking Blue Shield, Arkansas 293 and 210; California is the same; Colorado is 348 and 250; and Delaware is 250 and 254; and Illinois is 444 and 165. I was going down the line and I mean the variance is so great and the costs are going so high that really is this not a goose that laid golden eggs?

We are concerned, I think medicare is here to stay and we want to make it work. It should be responsive. We don't want to break the program. We don't want to break the people and keep raising the amount that is charged to people under medicare.

This is a great responsibility that is here on the part of Blue Shield, because you seem to have a bulk, such a bulk of the intermediate services that are being rendered. You have almost all. You are in Alabama, Arkansas, California, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, Vermont, and North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Wisconsin, and Puerto Rico—a great responsibility on your part here.

Mr. PARISH. If I may respond to the comments with reference to the table you were quoting from, there does not appear to us to be relevancy between the reported average charges under medicare and Blue Shield allowances under the most widely held contracts.

For example, the report takes Blue Shield schedules, some of them developed some 15 years ago, and compares them to medicare charges in 1968. Obviously these fee schedules, most of which were designed for partial payments to physicians, do not meet current physician charges and were not intended to.

Senator RIBICOFF. But they were changed from time to time, the premiums were raised and you don't stay with a static schedule. These are the latest schedules and the 1965 physicians committee report under original medicare legislation specifically stated:

These schedules under service benefit plans could also be used for determining medicare payments.

How many Blue Shield plans had customary and prevailing contracts in wide use, that is, when medicare started?

Mr. PARISH. In wide use, none.

Senator RIBICOFF. No Blue Shield plans had customary and prevailing?

Mr. PARISH. Some did, but not widely. These were beginning.

Senator RIBICOFF. Some of them. But you did have a prevailing fee schedule in many cases, did you not?

Mr. PARISH. It depends on your term "prevailing." If you are talking about "were we aware of prevailing charges in communities," yes. If you are talking about community profiles, no.

Senator RIBICOFF. They were based—in other words, you started with doctors and were concerned and worked it out and saw you were reaching a situation wherein certain income limitations, $5,000, $6,000, or $7,500, the doctors were going to take this as full payment for services rendered.

Now, the overwhelming majority of people in medicare would come under those categories?

Mr. PARISH. Exactly what was proposed in 1965, sir.

Senator RIBICOFF. I know, but why didn't it work? Did we receive so much more?

Mr. PARISH. The law moved to customary and reasonable fees.

Senator RIBICOFF. The law didn't say so. The law says you consider it.

Mr. PARISH. Excuse me, sir, we were specifically prohibited from using fee schedules or income levels in the administration of medicare.

Senator RIBICOFF. But you could get together with what was reasonable, customary, and consider it and work it out. Let's say, so it is past now, do you see any reason why we should not go to a fee schedule now?

Mr. PARISH. Again, if I can refer back to testimony—if the objective of the program is to stabilize, save money, cut down the cost—no reason at all. It would be a simple process.

It can be done either on a schedule or variety of schedule basis.

Senator RIBICOFF. When you were doing it, most of the doctors working with you before medicare were going along with a prevailing fee schedule?

Mr. PARISH. Yes; with fee schedules developed in the communities with income levels.

Senator RIBICOFF. With income levels and those income levels were basically generous when you take into account what the average social security beneficiaries were getting?

Mr. PARISH. Yes, updated repeatedly.

Senator RIBICOFF. What would be wrong for medical societies, carriers and medicare authorities in sitting down with medical societies and working out a prevailing fee schedule?

Mr. PARISH. This can be accomplished.

Senator RIBICOFF. It could be?

Mr. PARISH. Right.

Senator RIBICOFF. Is there a question in your mind that it would work?

Mr. PARISH. No. We would suggest, and if I may digress for a moment to bring in medicaid for purposes of illustration, it is my personal opinion, and it has to be that, Mr. Ribicoff, that had the Government sat down with medicine in the development of medicaid, where we are talking strictly about indigent and medically indigent persons, had that been done and a schedule for an income allowance or something of that nature attached to a fee schedule, it is my personal feel-

ing that medicine would have gone along with that and you would have had that kind of approach certainly under medicaid.

Senator RIBICOFF. Now, it was not done. I suppose a lot was done with opposition of medicare. HEW was anxious to make sure the plan would work. They had been fighting the doctors or they figured they would give into the doctors and capitulate completely and give them a blank check, which they did, which was to the discredit of HEW in my opinion and now we are in the mess we are in. We are in a mess and an expensive one. Those of us who were for medicare and those of us who were against medicare realized if we have a system that is part of a social and political system of this country, we had better make it work.

That is the purpose of these hearings and the objective of this committee is as to what should we do to make the necessary changes to assure that medicare will work without breaking the system.

Now what we seek from men like yourself, who have had all of this experience, is your suggestion as to what should we do now? We can't go on the way we have. What was the figure about how much more it cost us, do you remember?

Senator WILLIAMS. Medicaid was to increase by $238 million initially and it is running $3.5 billion now. I don't know the exact figures on medicare, but it is not substantially different.

Senator RIBICOFF. You people want to take medicaid and HEW criticizes you for the bad job you have done in California and New Mexico.

Mr. PARISH. We want to take medicaid——

Senator RIBICOFF. Don't you want to take medicaid? You would like to administer medicaid, too, wouldn't you?

Mr. PARISH. We think medicaid can best be administered by use of private carriers. We are not asking for exclusive rights or a monopoly in the area. We think the provisions, for medicaid should be the same as medicare.

Senator WILLIAMS. Are you handling both medicare and medicaid now?

Mr. PARISH. In certain areas, yes, a good deal less in terms of medicaid than in medicare.

Senator WILLIAMS. How much do you figure you make on handling the two programs?

Mr. PARISH. Nothing.

Senator WILLIAMS. Nothing at all?

Mr. PARISH. Nothing.

Senator WILLIAMS. How many of these programs, or in how many States were you operating these programs of medicaid and medicare? Have you expanded coverage?

Mr. PARISH. We started up with 33 carriers in medicare and we still have 33. Medicaid has grown from zero to roughly 21 or 22 State areas now.

Senator WILLIAMS. You would have liked to have represented all of them, is that correct?

Mr. PARISH. Not necessarily, no. I personally dislike this kind of monopoly, Senator.

Senator WILLIAMS. Do you want to continue operating or representing the areas you do now represent?

Mr. PARISH. Yes.

Senator WILLIAMS. Purely from a standpoint of just a public-spirited movement, no profit?

Mr. PARISH. Our organizations were founded as public service organizations purely and simply, yes.

Senator WILLIAMS. Considering there is no profit or incentive to having it, if a new system were set up which eliminated you, it wouldn't affect your operations and I assume you would have no concern?

Mr. PARISH. We would have great concern.

Senator WILLIAMS. Why?

Mr. PARISH. We are an established public service organization. This is our function, sole function, Blue Shield plans, to serve in the public interest in the communities in which we are represented, and we think also the alternatives would be worse, frankly.

Senator WILLIAMS. I repeat, I am amazed by this free public spirit of everybody coming in and wanting to represent these programs and do it for nothing. I am surprised.

Mr. PARISH. We don't like it and like the commercial carriers who testified before about it, we tried to change it, but were unsuccessful.

Senator WILLIAMS. Why should the Government change it when you are all so happy?

Mr. PARISH. We are not happy, believe me, sir.

Senator WILLIAMS. Well, you are all continually wanting to expand. Isn't it a fact there is a little profit in there somewhere?

Mr. PARISH. My answer is, there is none.

Senator WILLIAMS. I don't criticize the profit motive, I defend it, but I am puzzled here at all of this great interest by both nonprofit organizations and in public organizations in wanting to do something for the Government for nothing. I just wish that somebody would frankly admit why you are doing this and why you like to do it, maybe it spreads your workload costs and maybe helps you operate your whole broad operation more economically. I can understand that, but there is an incentive somewhere and I will accept that it is nothing but public spirit. But I say it is rather amazing.

Mr. PARISH. In the first place, Senator Williams, we are established—that is, our plans, I should say, not the organization itself—but our plans are established both under special enabling legislation and in the various States as nonprofit corporations.

Senator WILLIAMS. But it would not affect the financial operations of the program, as far as medicaid and medicare, if other arrangements were made for handling it? That is the question I want an answer to.

Mr. PARISH. You say it would not?

Senator WILLIAMS. I am not suggesting we may want to do it. If Congress decided to have other methods of handling the claims, as I understand it now it would not affect your operation or any other operation because you are not making money with it anyway?

Mr. PARISH. In the short run, it would affect it dramatically, yes. We would be faced with enormous reductions in personnel and property.

Senator WILLIAMS. I assume it would be picked up by whatever organization took it over.

Senator RIBICOFF. What is your average reimbursement fee per case under medicare?

Mr. PARISH. Are you speaking of administrative cost?

Senator RIBICOFF. No, what do you receive from social security?

Mr. PARISH. That is an administrative cost. Again we have to speak in averages. Mr. Rhea may have it, but the two plans that will be testifying will be able to answer this. Well, I have it.

Average is 3.29—I am sorry, $3.29 is the median.

Senator RIBICOFF. What is the range among Blue Shield plans?

Mr. PARISH. The average is 3.29.

Senator RIBICOFF. An average of high of what and low of what?

Mr. PARISH. This is indicated from October to December 1969, and ranges from a low of $1.74 to a high of $6.02.

Senator RIBICOFF. Who is $1.74 and what is $6.02?

Mr. PARISH. Rhode Island is the low and District of Columbia is the one that is high.

Senator RIBICOFF. Would you be available, because we are going to have to recess until 2 o'clock and then listen to Mr. Herbert of Florida Blue Shield and Mr. Rinehimer of Pennsylvania, and then the staff might have some questions they might want to ask and would it be convenient for you to come back at 2 o'clock?

Mr. PARISH. Yes.

Senator RIBICOFF. Or 2:30.

Well, the committee will recess until 2 o'clock.

(Whereupon, at 12:50 p.m., the subcommittee recessed, to reconvene at 2 p.m. of the same day.)

Senator RIBICOFF. The committee will be in order.

Is Mr. Herbert here?

All right, Mr. Rinehimer, we will hear from you now to save some time. You may proceed.

STATEMENT OF ROBERT E. RINEHIMER, SENIOR VICE PRESIDENT, PENNSYLVANIA BLUE SHIELD

Mr. RINEHIMER. Thank you, Mr. Chairman. I am Robert E. Rinehimer, senior vice president of Pennsylvania Blue Shield, which currently serves 7,500,000 people or 65 percent of the population of Pennsylvania. Of that number 5,500,000 are subscribers under our private programs; the balance are covered under medicare, medicaid, and CHAMPUS.

More than 18,000 doctors are registered with Pennsylvania Blue Shield as participating doctors. We also serve, on behalf of many Blue Shield plans throughout the country, as the principal negotiator and contractor with many major national employers, to provide their employees with programs covering physicians' services. It is estimated that there are 1,300,000 people enrolled under such national programs.

Thus, our Blue Shield plan has great responsibilities in both the private and public sectors and on both the national and local levels.

Today we appreciate the opportunity to address ourselves to the role which we play in the public sector, particularly with respect to medicare part B.

In our presentation, we would like to discuss briefly the following subjects as they relate to Pennsylvania Blue Shield: The report of the staff to the Committee on Finance, U.S. Senate; our medicare operations; our prevailing fee program; utilization review activities; and certain suggestions for improvements which might be considered.

It is always easy to criticize any report by trying to punch holes in it. In our view of the staff report we noted that many questions were raised about misinterpretations of the law, the forms of administrative practices, the validity of methods for determining customary and prevailing charges of doctors, the effectiveness of cost controls, abuses, or misuses of the program and the future prospects.

They, along with a host of other questions, were indeed legitimate ones and needed to be raised. Certainly, when millions of dollars are being spent on such a massive program as medicare part B, then all carriers such as we must be subject to an increasingly sharper focus by the public—is there honest stewardship?

Although we could merely say: "We like this"—"We don't like that" about various points in the staff report, we believe it would be more helpful to the committee if Pennsylvania Blue Shield were to describe some of its own philosophy and experiences that are relevant to the matters at hand here.

Late in 1940, Pennsylvania Blue Shield began to function as a "Service Plan" under the supervision of the Insurance Commissioner and Secretary of Health of the Commonwealth of Pennsylvania. Benefits, very limited in scope, were provided under a plan A fee schedule. Single persons with an annual income of $2,000 or less and persons with dependents having an annual income of $4,000 or less who became enrolled thereunder were entitled to service benefits; that is to say, when they received covered services from participating doctors of Pennsylvania Blue Shield, such doctors would accept the Blue Shield allowance as payment in full.

However, with the passage of time and the rise in incomes, fewer subscribers qualified for service benefits under plan A.

Consequently, in 1954 the plan B fee schedule was introduced. Allowances averaged about 45 percent higher than those of plan A. However, income levels were raised for entitlement to service benefits: Single subscriber—$4,000; a subscriber with dependents—$6,000.

But here again we witnessed an erosion of the effectiveness of our service benefits. As incomes continued to rise, fewer subscribers could qualify under the aforementioned income limits. As a result, they were experiencing more out-of-pocket costs. By 1960 we were attempting to improve the service-benefit picture and concurrently our fee schedule allowances. The Insurance Commissioner of Pennsylvania, however, directed that we take a hard look at the overall situation. The hard look turned out to be a 5-year project.

During the period of 1961 through 1965 we made surveys of our participating doctors to determine their types of practices; the percentage of time devoted to their specialties; their certifications by specialty examining boards; and charges made to their patients. We tabulated and analyzed the charges from more than a million claims. The Opinion Research Corp. of Princeton, N.J., was hired to survey both Blue Shield and non-Blue Shield patients as to charges being made to them by doctors. We established in 1962 a utilization department which is staffed by 29 people.

The board of directors and the Pennsylvania Blue Shield Subscriber Advisory Council (an independent body comprised of 30 representatives from management, unions, various professions other than medical, housewives, et cetera) made independent studies of the adequacy of our service benefits. Action was initiated to refine terminology or nomenclature of medical procedures in the light of advances in medical science and new techniques. Joint studies were made with representatives of the Pennsylvania Medical Society, the Pennsylvania Osteopathic Association, and the Pennsylvania Dental Association.

Where did all this activity lead us? Whereas we originally had intended to develop a new fee schedule program with higher income limits for service benefits, we ended up with something quite different. Pennsylvania Blue Shield realized that some rethinking had to be done about the traditional approach of providing limited service benefits on the basis of a fixed-fee schedule. Why?

1. That approach ensured that only those persons whose incomes are within established limits will receive no charge for services performed by participating doctors who have agreed to accept the Blue Shield allowance as payment in full.

2. Subscribers themselves desired more and more that payments be based on value of services received—not on their incomes.

3. In a report filed with the New York State Insurance and Health Departments at the request of the Columbia University School of Public Health and Administrative Medicine, the point was made by the study staff that the ultimate aim of Blue Shield could be service benefits for all subscribers regardless of income.

4. The data which we had collected during 1961 through 1965 about charges of doctors revealed that there was a marked variation in the customary charges of individual doctors and a lessening of this variation within specialty groups in geographical areas. Doctors tended to have uniform charges regardless of the patient's income.

5. A fixed-fee schedule can only work satisfactorily or equitably when it is applied to an area that has economic homogeneity. We know that no fee schedule can be developed which will not be above the charges of some doctors and below the charges of others inasmuch as costs, habits, standards, et cetera, vary so much from one part of Pennsylvania to another.

Thus, the overall question haunted us: is there another way of providing for meaningful service benefits without increasing fee allowances across the board?

For the reasons I have just given, I admit forthrightly to you that after years of study we literally backed into the concept of a new plan that we called the Pennsylvania Blue Shield prevailing fee program. It was designed to provide for: (1) the payment to a participating doctor of his fee if it met certain criteria; and (2) the assurance to the patient that there would be no additional charge regardless of his income. The criteria we established were:

"Usual fee"—that fee which the individual doctor ordinarily charges for the performance of a procedure. This term is synonymous with the term "customary" as used in medicare.

"Customary fee"—the maximum fee or the lid set on the range of usual fees of doctors of similar training and experience in a given geographical area for the performance of a procedure. This term is synonymous with "prevailing" as used in medicare.

"Reasonable fee"—that fee which varies from the "usual" or "customary" by reason of unusual clinical circumstances involved in the performance of a procedure.

Hereafter, in my remarks I shall use the medicare terminology: customary and prevailing.

On August 1, 1965, we put the prevailing fee program into effect for a group of 3,000 persons. Since that time we have enrolled 434 groups totaling approximately 1,250,000 persons. We are now beginning to market the program to the public in general. Since the inception of our prevailing fee program, we have changed the "prevailing fee" once—that was as of August 1, 1968, and the calculation was based on "customary fees" as of April 1, 1968. Prior to the medicare "freeze" in December 1968, doctors could change their "customary fee" for an individual procedure only once in any 12-month period.

However, such changes were subject to the limit imposed by the "prevailing fee."

On April 1, 1969, we began to make still another study of billed charges on claim forms and a reevaluation of what we call "charge classes"—groups of geographical areas in our State which exhibit similar charging practices within various specialties. This study is about completed.

(I might point out parenthetically here that during this study period we have not acted on any requests for changes in usual fees or customary fees, as known in medicare.)

On the basis of such study, we intend on July 1, 1970, to update the profiles of customary fees of individual doctors and to establish a new prevailing fee or limit to be used for our regular prevailing fee program.

Senator Ribicoff. That bell means a vote, and I will have to leave, but I would like you to continue, and the staff can continue with you, but I have a couple of questions first. I took the liberty of reading ahead.

On page 12, on your matter number 5, how serious are you that you would like to work out with the Social Security an overall possibility of receiving a blank underwriting fixed monthly premium payment to work out a method of coverage under medicare?

Mr. Rinehimer. Senator, we would like to explore that very seriously. Our reasons are these: (1) We feel that the program would not loom up so monolithic or massive in the eyes of the doctors in Pennsylvania. It would bring on an underwritten basis a local character or local identity to the program. (2) We have 18,000 participating doctors. If this were to be identified as part of the Pennsylvania Blue Shield program, it is conceivable, this is what we would like to explore with the providers, to have the same arrangement and participating doctors. If they participate and provide covering services then they agree they will not make additional charges to the patients. (3) At the present time, we cannot charge any reserve expense to medicare and I felt that if we had some arrangement like this it is conceivable we might be able to factor into the arrangement some element which would be in the way of reserve.

Senator Ribicoff. Would you work out different experiments of group practice, prepayment provisions like the Kaiser plan or group health insurance? Would you conceive of varied responses in differ-

ing sections of Pennsylvania or be under the thumb completely of the Pennsylvania Medical Society?

Mr. RINEHIMER. No, we would not be completely under their thumb.

Senator RIBICOFF. You see, what you say intrigues me because what you suggest I had in the back of my mind. There can be very well authorization of legislation. Let the Secretary of HEW run experimental pilot programs throughout the country, two or three of them, to see if there are alternatives that could give better services at lower cost and if you have any thought in mind, I would appreciate at your earliest convenience, sending me what you have in mind you would like the Pennsylvania Blue Shield to work out. You intrigued me very much with that suggestion and I like it.

Mr. RINEHIMER. We shall be glad to draft a proposal.

Senator RIBICOFF. Now our staff will take over.

STAFF. Please proceed.

Mr. RINEHIMER. However, before we put the updates in, we must clear with the insurance commissioner and the changes must be in bounds and this is what he said:

> That any change in the overall level of payments to doctors that would be greater than the change in the consumer price index for a comparable period cannot be put into effect without prior approval of the Insurance Commissioner.

We have given you the foregoing history because it relates to many subjects discussed in the staff report. With the advent of medicare in 1966, we applied the criteria of our prevailing fee program to determine reasonable charges on medicare claims since it does not take into account the income or economic status of patients.

From day one of medicare up to the present day we have been consistent in our administration of our private prevailing fee business and medicare part B. Medicare claims are processed through the use of the same data (an accumulation of over 400,000 customary charges of individual doctors) and prevailing charges determined by the same methodology as we use in our prevailing fee program for private business.

Like other carriers we had the onslaught. We had to more than double our operating staff. At one time we had 537 persons in our Government programs division, but by effecting certain changes in reorganization and procedures, intensifying training, improving data processing systems, we have been able to reduce such number to 297—and yet handle greater volumes more quickly and efficiently.

Because of the volume of medicare claims handled by Pennsylvania Blue Shield (over 2.2 million claims received in 1969) it is mandatory to make extensive use of electronic data processing and microfilm equipment. The use of the latest computer and computer-related equipment helps to process claims quickly and accurately at a lower cost. Also, the extensive use of microfilm gives quick access to historical data and reduces storage costs.

Every effort has been made to keep to a minimum the amount of manual intervention in the claims processing system. However, the manual system has been designed so that there is a smooth flow of claims compatible with the electronic data processing system.

Some of the features of the system are:

(1) Control of the claim. From the time the claim is entered into the system (usually the same day it is received), the computer has

control of the claim. It is known, for example, in what section of what department the claim is located. The system automatically identifies those claims that have remained in any location over specified time limits. Once the claim has been processed to a final disposition, computer and microfilm records permit quick access to historical claims data.

(2) Accurate and timely financial information in accordance, with acceptable accounting standards.

(3) Ability to process and record all postpayment accounting transactions.

(4) A work measurement program (a byproduct of the processing system) that enables management to evaluate performance and project staffing requirements.

(5) Extensive analysis of medicare claims by the computer for use in utilization review.

(6) Retention of all historical claims data on computer tape to insure rapid and economical retrieval of data needed for statistical analysis.

Some of the techniques used are:

(1) Uniform (classroom) training of personnel to insure correct and consistent processing of claims.

(2) Continuous medicare educational program for doctors and office assistants.

(3) Complete documentation of internal procedures to insure consistent processing.

4. Constant interface and communication with SSA regional and district offices.

5. A quality control program to insure accurate coding of claims.

Some of the results are:

1. Claims are processed in an average of 10 days versus a national average of 22 days for all carriers.

2. Correspondence is answered in an average of 8 days.

3. A decreasing number of complaints is received through SSA district offices and from other sources which indicates that the quality of processing is constantly improving.

4. An administrative cost that is 10 percent below the national average of all carriers.

Much reference has been made in the staff report to utilization review. Frankly, it was indeed proper. We know from experience in our own business that, as programs have become more comprehensive and complex, utilization review becomes an increasingly important tool. The current primary objectives of our utilization review program are to detect, eliminate and—above all—prevent improper utilization of benefits through the joint efforts of alerted professional organizations and Blue Shield, all with the common purpose of encouraging optimum medical care at a reasonable cost.

Utilization review activities may be classified into four distinct but related areas;

1. Detection methods;
2. Case development;
3. Possible actions; and
4. Educational activities.

Detection methods in addition to the ongoing screening of all claims, include the following:

1. Prepayment reviews of unusual claims. There were 3,357 such reviews during 1968, and 18,659 during 1969.

2. Routine claim investigations may be conducted by mail, phone, or through personal interviews to obtain information from hospital record rooms and/or patients in order to verify reported services. These routine investigations are based on a random sample of paid claims. During 1968, a total of 2,138 routine claim investigations were made under medicare. During 1969, 3,719 claims were investigated routinely.

3. Special claim investigations generally are initiated on the basis of suspected overutilization or misutilization of program benefits. During 1968, a total of 1,115 special claim investigations involving 34 doctors were made under medicare. During 1969, special claim investigations totaled 1,647 and involved 72 doctors.

4. Investigations of complaints from beneficiaries or providers. There were 87 such complaints investigated during 1968, and 149 during 1969.

5. Statistical and computer review of accumulated data.

Any or all of these methods of detection may be used in the initial development of a case. Later, a case may be referred for professional review to the vice president of medical affairs, medical directors, medical advisers, or the peer review committees established by professional organizations.

The action taken in any given case will depend upon the circumstances and may include the recovery of moneys, the reduction of payments, the disallowance of services deemed medically unnecessary, disciplinary action through the appropriate professional society, continued statistical review, the referral of suspected fraud cases to the Bureau of Health Insurance.

Pennsylvania Blue Shield continually develops and implements educational activities intended to increase public and professional appreciation of the importance of proper utilization of health care benefits.

We estimate that at the end of 1968, actions of our utilization department since the inception of medicare resulted in savings of $806,000 based on refunds and reductions in claims payments. During 1969, such savings were estimated to be $1,030,000. Although this is not the report we do have for 1969 a report on having a good tight system for duplicate checking and we have rejected about 80,000 claims and if we had not rejected and found them to be duplicates, we would have paid $5 million if these duplicates had not been found.

In summary, Pennsylvania Blue Shield's utilization review program with the increased cooperation of the professional organizations, has demonstrated the ability to develop methods which will help insure responsible control of the costs of medical services.

In closing, we would like to offer these comments for your consideration. It has been alluded to today.

1. Let there be a loud, clear statement as to what medicare is intended to do for the beneficiaries. Is the aim to provide mere indemnity payments or to meet the bill in full as nearly as possible, with the exception of the deductible and coinsurance? Somehow back home we are inclined to believe that the beneficiaries are convinced it is the latter.

2. If fee schedules are to be imposed, then we can only refer to our own experience; it is impossible to construct them in a manner that

will be equitable to all beneficiaries, the doctors, and the Government. Any inadequacies will only shift the cost to the patient.

3. If the Federal Government is to insist on a national uniform methodology for determination of reasonable charges for medicare rather than that which we use for our private business, then it appears to us that this would conflict with the following provision of the law: "that the charge be reasonable and not higher than the charge applicable for a comparable service and under comparable circumstances to the policyholders and subscribers of the carrier."

At least under the present ground rules we have consistency in administration of our private Blue Shield business and medicare part B.

4. More money and time must be spent on utilization review, especially in the area of communications with beneficiaries, organized medicine, and individual doctors. Most doctors are performing a dedicated service for the aged; yet they are confused and discouraged by the mounting criticism of the medicare program which reflects on them.

Pennsylvania Blue Shield must communicate to them more and information about the developments in the medicare program, especially with respect to its findings of charging patterns, trends in charges for various services, and the increasing cost of financing. Now this leads me to our final point which we touched on briefly here.

5. One can't peddle oranges with an empty cart. True, there are many innovations being tried in the delivery of health care to seek greatest efficiencies and economies. But they take time. In the meantime, there are millions of the aged who need care now amidst the cries about shortages of doctors and the escalation of costs. Always looming up are such questions as: Just what can be done? Is there a way to contain costs? What incentives can be provided? Can there be prospective rating of costs?

Therefore, we would like to pose this—can an answer be found in this suggestion: Should the Social Security Administration explore with one or more carriers the possibility of having beneficiaries in a carrier's service area covered on an underwritten basis?

SSA and the carrier would negotiate a fixed monthly premium payment for an agreed-upon time period. Under the arrangement the carrier would be free to use its own administrative expertise and to work with providers of services in the development of incentive programs.

It seems to us that some form of underwriting would enhance a greater research activity and experimentation upon the part of the carrier. In any event, we do pledge to you, HEW and SSA our willingness to cooperate in any joint studies, with a view of determining the feasibility of this or other approaches.

Mr. Chairman, this concludes our statement. With me are Sydney E. Sinclair, M.D., vice president of Medical Affairs of Pennsylvania Blue Cross, and William E. Keller, Director of our Government Programs Division. We shall be glad to try to answer any questions you may have.

Senator Long. I would like to hear the remaining witnesses and then we will ask some questions and the staff would like to ask questions.

So I will call the next witness and he can conclude his statement and then proceed to ask questions.

I will call John Herbert to testify on behalf of the Florida Blue Shield. You are testifying for both Blue Shield and Blue Cross?

STATEMENT OF JOHN W. HERBERT, SENIOR VICE PRESIDENT, FLORIDA BLUE SHIELD

Mr. HERBERT. Yes, we are the intermediary.

Senator LONG. All right, sir.

Mr. HERBERT. Thank you, Senator Long.

I am John W. Herbert, senior vice president of Blue Shield of Florida, Inc. and of Blue Cross of Florida, Inc., located in Jacksonville, Fla. Florida Blue Shield is contracting as carrier for medicare part B and Florida Blue Cross is a subcontractor to the Blue Shield Association for part A of medicare.

With me is Richard T. Shaar, M.D., who is our full-time medical consultant, and Mr. W. J. Stansell, who is vice president of Physician Affairs.

At your request, we appreciate the oportunity to testify and will look forward to responding to your questions.

It will be our intention in this testimony to:

1. State our reaction to some of the statements and conclusions which were reported to you by your staff in its report of February 9, 1970.

2. Present to you the current state of our ability to act as a carrier under the law as presently written and the regulations as have been promulgated by the Secretary of Health, Education, and Welfare.

3. We also hope to make a few suggestions which we see as having a good possibility of improving this service to the social security beneficiaries who obtain covered medical services in the State of Florida.

At the outset, Mr. Chairman, let me take this opportunity to tell you who we are and who we represent. Florida Blue Shield is incorporated under the laws of Florida and is a prepayment and medical care plan operating under the guidance of the Florida Medical Association and the State insurance commissioner for the people of Florida.

In that regard, we serve through private contracts 1.2 million Floridians, over 200,000 under the Campus program as well as a permanent resident population of medicare part B beneficiaries of about 800,000, which is augmented by our winter and other seasonal visitors to a million or more at times.

This is not in the testimony, but when we were trying to decide how to staff up for this, we discovered that there were 16 million visitors to Florida every year, but nobody knew how many of those were over 65 years of age.

Senator LONG. There are a couple of questions I would want to ask now because I have to preside over another committee.

I would like to ask you why Florida Blue Shield initially refused to provide SSA with the names of physicians who had been paid $25,000 or more in public funds under medicare?

Mr. HERBERT. Well, we felt that this was in keeping with the original agreement we had with the Social Security Administration to furnish all of the documentation through the medical practice and to describe fully all of the circumstances that might lie within the medical field, but the disclosure of the name was not really a reflection on the type of care that was being given.

In other words, we were trying to get in the medical framework and not in the personal framework.

Senator LONG. On July 25, 1969, the Bureau of Health Insurance asked you to thoroughly review medicare payments to 266 physicians—one-third of the physicians who were paid $25,000 or more in 1968—including some members of groups. Those doctors were selected on the basis of initial analysis of physician payment profiles by the committee staff. Social Security just reported that, based upon work done so far on those 266 profiles, allowing for some overlap, that 87 had been referred to medical societies for peer review and 21 determinations of overpayment were made with recoveries in 15 cases. Another 20 physicians were being reviewed for possible fraud. Obviously these results are only partial, but significant. A complete review of all physicians' profiles would undoubtedly disclose quite a bit more.

Why didn't you do a case-by-case study of these physicians until December 1969, and why didn't Florida Blue Shield detect these alleged frauds and abuses before the data was collected for the Finance Committee?

Mr. HERBERT. Senator, I think the answer would be, we were not surprised there were this many physicians making or receiving this amount of money. Florida has so many elderly people plus visitors and in some communities the population of the people over 65 is very high and it was not a surprise to us that these people received or these doctors received this amount of money.

Senator LONG. You had 128 cases already which would appear to be obviously cases of irregularity and 20 of them are cases of possible fraud. Why was something not done prior to that time?

Mr. HERBERT. These are the only ones identified in the report. We have been referring cases for possible fraud all along and investigating all along. These were the particular physicians who achieved over $25,000.

Senator LONG. Well, as I understand it, these cases are for the most part cases that you had not picked up before and made reference to and I am wondering why not?

Mr. HERBERT. I think we were working on this all along, Senator, and these just happened to be those over $25,000. In other words, the $25,000 mark was not a point to us where someone might be suspected of doing or, rather, giving overenthusiastic treatments or practices that might not be ethically correct. Any amount of money.

Senator LONG. If you had been doing it on all, including those over $25,000, how many have you referred to medical societies for peer review and how many have you undertaken to recover against because of overpayment and how many have you referred for action on the basis of possible fraud?

Mr. HERBERT. I am going to ask Mr. Stansell if he can answer it specifically for you.

Well, I see the physicians here we have on flag at the moment, that is, whom we are examining their profiles, some of whom we have send in their claims once a month, or altogether at one time so they can be turned over to Dr. Shaar and reviewed individually, in 1968 we had 59 physicians and in 1969 it was 150 physicians and currently we have 19 that we are holding pending a complete claims audit, and 18 we have that we referred all claims to a claims review section and 154

are under investigation for various parts of their practices and on whom we have suspended payments, so that I think altogether this runs to around a total of 198.

Now the decrease in the payments that we made to physicians because of surveys that we made on their practices, in 1969 the first 6 months, this was $1,348,000. In the second 6 months it was $469,000.

Now I would like to make the observation that a good many of the areas of concern have been in the outpatient, the office care area, and I think the gentleman from the Group Insurance Plan of New York commented on that.

When you furnish comprehensive outpatient benefits, you have to have well-defined norms and screens. For the first time there was a benefit program available to people over 65 and I think both doctors and beneficiaries wanted to participate in this to the fullest.

We know that this has been the case and that there is a great deal of—we call it "over-enthusiasm," but it was largely brought about by not having had this benefit pattern before. In that connection, I would like to make this comment.

For a number of years a good many physicians in our State have been asking us to write comprehensive out of hospital benefits—office care, home care, X-ray, laboratory, diagnostic procedures of all kinds. Now there were many reasons for this but this came principally from physicians who practiced out of the hospital.

We told them we didn't have sufficient information, actuarial information, statistical information, to go ahead and design a program like this and price it and offer it to the general public. In other words, we didn't think that our plan had sufficient reserves to throw out this type of program because of the age of a good many of the people in Florida and because you have to sell it group by group by group and you don't always get a good risk when you do it that way.

That was one of the principal reasons why we were anxious to participate in the medicare program when it came along, because this program did provide those benefits and the doctors on our board and throughout the Florida area are responsible for this and felt that the data that would be collected from this would be very helpful to us, then, in developing comprehensive coverage to offer to the general public.

Senator Long. Fine. You may proceed with your statement now, sir, if you would.

Mr. Herbert. There are over 8,000 physicians rendering services to these people and to a Florida population of approximately 6 million people. Throughout our statewide organization we have more than 2,200 employees devoted to serving these more than 2 million Floridians. In the testimony of the National Association of Blue Shield plans of 1965 and earlier, many statements were made concerning the ability of the Blue Shield plans to act as carriers for the medicare part B program.

These claimed abilities were: One, knowledge of charging practices of physicians; two, established communications channels with practicing physicians; and, three, an already existing system of review of unusual cases. I want to reconfirm that we had and continue to have those abilities and the differences which are evident today are only a matter of degree and sophistication.

Some of the problems that came along, Senator, came before the benefit pattern of medicare was extremely different than the pattern which we had in our own private business.

PAYMENTS TO HEALTH CARE PRACTITIONERS AND UTILIZATION REVIEW

With respect to the number of physicians in Florida who received directly or indirectly medicare part B funds in the year 1968 of over $25,000 as detailed in your staff report, we have developed a comprehensive program of computer and human review to screen out those who may have unusually uncommon practices when compared with other physicians of like practice and locality.

We have, in fact, gone further than this in that we have studied the practices of all physicians reporting claims under the medicare part B program for both years. For the record, we have always reported direct payments to the IRS, when the total was $600 or more. So all of the income that these physicians received was reported to the Internal Revenue Service, whether it was from our own business or CHAMPUS or the medicare.

Here, as I stated before, there is only a difference of degree between what we have done for the past 20 years and what we are currently doing. Long before medicare, our concern for the proper use of the medical dollar for our subscribers was demonstrated by the fact that we obtained the services of a claims committee of practicing physicians who gleaned the unusual practice or practices from the daily, weekly, and monthly flow of claims to detect those few, but potentially expensive, deviations from the norm which should not be the liability of Blue Shield.

We established the practice of conferring with the involved physician and his peers to determine the validity of his claims. Due to the breadth and the depth of the medicare part B benefits, we were aware that the problems of utilization would be greatly magnified, due to the scope of the benefits and to the great volume of cases which we would be required to handle.

Early in the program we continued our manual methods of detecting unusual practices and in some outstanding cases we were quite successful in investigating and controlling situations which resulted in a greater liability to the medicare program than we thought to be correct.

During the early days of the program, the volume of claims predicted by some and denied by others was overwhelming to us as I am sure it was to almost all of those carriers handling medicare part B and we concentrated our efforts both in the manual processing and computer areas to the prompt and proper payment of claims as quickly as possible.

As we overcame the enormous problems of this volume of production, we began to devote more and more of our time to quality control and closer review of payments. It was not a case of being unaware that these actions should be taken, but one of priorities.

Early in 1968 we felt that we had sufficient information on which to base comparisons of practices in our State and we began to refer an increased number of cases directly to county and State professional organizations for their review and advice. This resulted in decisions which can only be characterized as in the interests of the programs.

For instance, in the case of several physicians the doctor's peers felt that we should not be paying over 50 to 65 percent of the amount being billed due to the excessive number of services being rendered per subscriber. We applied these parameters to the practice and found in most cases that the involved physician adjusted his practice and his overenthusiastic care of patients to meet with the approval of his peers.

Later, in 1969, when we had developed a sophisticated comparison program for utilization review study, we entered into an agreement with the Florida Medical Foundation (the Florida Medical Foundation is a nonprofit corporation of the Florida Medical Association and controlled by its governing body) to provide a statewide control on these cases which we felt needed peer utilization review.

The Florida Medical Foundation had already set about establishing county medical society review mechanisms and is currently at work on 79 cases. Preliminary reports on several of the cases indicate that this will truly be a process of peer review and not one of peer justification. In some cases, the county and State medical association have indicated that there will be further disciplinary action by the medical societies on some cases.

Of course, this is not an implication of fraud, but simply of practices not in keeping with the ethics or acceptable standards of the association.

Our combination of a well-trained medical review staff and claims processors, a staff of 25 persons in our utilization review department, an experienced claims review committee of practicing physicians, sophisticated computer programs, and the wholehearted backing of organized medicine in Florida will prove the correctness of the statement in your staff's report that "the key to making the present system workable and acceptable is the physician and his medical society."

To date we will briefly give you some figures on savings which have been affected by both our detections system in house as well as the peer review system and the results of the investigations which have revealed only a few examples of fraud and the disposition of cases as expressed in dollar amounts.

For example, we are currently holding cases which are under review in the amount of about $850,000. In the instance of the physicians who have been the subject of peer review, it can be demonstrated that, as a result, we did not pay $1.8 million in 1969.

In one case, upon review by our claims committee and his local medical society, it was determined that instead of paying $222 for lab work on each of his patients, the medicare liability should be reduced to $15 per case and this resulted in a savings of over $20,000 per year. I might try to explain that one because it looks so odd, but this particular physician put in a complete lab. He does his work in his office and then he started doing a complete workup on all of the patients, beneficiaries that came to him.

When these cases came in and showed this $222 per case, it was referred to Dr. Shaar and he took it up with the claims committee and said, "that is fine, it is wonderful, but it is not necessary to do all of that work." And they covered it back to 15 per case.

Long before it was recognized by the Government agency handling the program, we discovered several instances of excessive injections

and it was the decision of our claims review committee that these should not be the liability of the medicare program. This restriction resulted in a considerable dollar savings to the medicare program.

Now we cut the injection rate down considerably, even before the regulations were promulgated.

Very early in the history of medicare, we discovered that one physician was billing us or his medicare beneficiary patients for so-called finger surgery to the ear and we set about immediately to disqualify this type of service for medicare liability. These "surgical" services were billed to us at about $300 to $400 each and it is our estimate that our denial of liability for have not only resulted in these patients obtaining better care, but has saved the medicare program many thousands of dollars.

Senator Long. What is that, that finger surgery?

Mr. Herbert. To relieve deafness, massage the Eustachian tube and it corrects deafness and this is a procedure which this man's father invented and he is doing it, and it is well known as the Munsey procedure.

Senator Long. From the inside or outside?

Mr. Herbert. From the inside and people will attest that this corrected their hearing, so when this came up, we said, "Fine, but let's be a little scientific about this. Let's have each beneficiary examined and their hearing level determined before and after the surgery."

This was not acceptable to the physician and we cut the payments off right from the very beginning. I might say he complained bitterly to the SSA through his Congressman in Baltimore and made trips to Washington, but in the end we prevailed that this was not the proper reliability.

Senator Long. Let me see if I understand what you are talking about. You might be doing that to a patient, but you wanted to determine that the patient had had a hearing impairment to begin with, and then you wanted to determine that he had done some good with it?

Mr. Herbert. That is right.

Senator Long. In other words, it was just to simply massage the Eustachian tube without evidence that: one, it was necessary and: two, it did good and was just a waste of money?

Mr. Herbert. We wanted him to have audiometer tests and other facilities like that to determine that there was some benefit here. We were not objecting to what he was doing even though the procedure cost about $350, it would do the trick and he didn't need to put anybody in the hospital.

If it can be done on that basis, fine. But we butted heads with this thing right off the bat. We finally stopped it. I don't know how much money it saved the program, but it was an instance of moving in early.

We have a staff of 25 persons in our utilization review department which has evolved over the past 20 to 24 months into a sophisticated educational and administrative operation, which provides close surveillance over the more than $100 million in part B medicare funds which we pay out annually.

Included in this department are five field representatives who are in constant and close contact with local practitioners and their medical institutions.

While the obtaining of refunds of overpayments for many reasons, including overutilization, is not the primary purpose of this operating department, the activities of the department for the year 1969 resulted in refunds of almost $100,000.

We continue in our search for better methods to identify, investigate, and resolve unusual utilization practices with the sure knowledge that this effort is directed toward a minor portion of physicians and claims.

The CHAIRMAN. I will have to go to the other meeting, but I will ask, after you complete your statement, which I have read, if both you and the other witnesses here will kindly cooperate with our staff and answer the questions that they would like to ask of you.

They want to ask for your suggestions and also ask specific questions. I would appreciate your remaining to do that. I have read your statement, sir.

Mr. HERBERT. Did you have any comment on the suggestions that were made about the possibility of cutting out the fair hearing requirements or raising the limit?

Now we get fair hearing requirements for as low as $2 and $5 and $10, and we have to put on these fair hearings.

In medicare A you have a regulation that the difference has to be $100 before you can have a fair hearing. But in medicare B it can be 50 cents. This should save a considerable amount of money.

Also, Senator, the deductible, and the combination of deductible and coinsurance, is an administrative monstrosity. It should be worked on.

The CHAIRMAN. That is what we are holding the hearings for.

Mr. HERBERT. I would like to bring one unusual situation to your attention before you go. It just came in the mail. It is indicative of a lot of things we get in Florida. This is a letter from a bank in Massachusetts about a man:

> The trust department of this bank has been handling the late Mr. So-and-So's finances for many years. He was in the habit of wintering in Florida and living in Massachusetts the balance of the year. He died on the 19th of July after having been confined to his bed for over two years with nursing and constant care.
>
> We have summarized his expenses for the period January 1, 1968, to date of death, July 1969, and enclose nine requests for payment of these expenses.

Copies of bills have been attached, some receipted, others not receipted. The canceled checks are included. He lists these nine requests.

> These requests are in the total amount of $42,564.22. Will you kindly mail the check payable to the estate of "Mr. So-and-So", care of our trust department. Thank you very much.

This claim was 2 inches thick when it came in and when we are through with it, it will be at least 5 inches thick. It will be a fair hearing from the bank, his attorneys, and everybody else.

We are saying this enters into the cost per claim in an area like ours where we have so many people from out of State who go back to their home and then file a bill with us, because the regulations are that the claim be paid where the service is received.

So our thinking here in showing you this is that a performance standard as to how a plan is performing can be a very complex thing. All of these factors should be taken into consideration, not just to say the cost per claim is a standard, because it isn't a standard.

It is not a measurable thing because it has elements in it in each area. If it was a standard, then the carriers that are low, the cost of claims in medicare B should also be low in medicare A, but such is not the case. There are vast differences.

The CHAIRMAN. Let me assure you that the reason we are holding these hearings is that we want your views on this. Sometimes in order to get the information we want, we have to ask our staff to abbreviate these statements and limit each witness to 10 minutes so we can let them hit the high spots and count upon our staff to see to it that we don't miss the lesser points in their statements.

Thank you very much for your statement.

(The balance of the statement follows:)

Twenty to twenty-four months into a sophisticated educational and administrative operation which provides close surveillance over the more than a hundred million dollars in Part B Medicare funds which we pay out annually. Included in this department are five field representatives who are in constant and close contact with local practitioners and their medical institutions. While the obtaining of refunds of over-payments for many reasons, including over-utilization, is not the primary purpose of this operating department, the activities of the department for the year 1969 resulted in refunds of almost $100,000. We continue in our search for better methods to identify, investigate and resolve unusual utilization practices with the sure knowledge that this effort is directed toward a minor portion of physicians and claims.

ADMINISTRATIVE RESULTS AND COSTS

We believe that the Blue Plans history of low administrative costs is one of the primary reasons for our selection as a Part B carrier and have directed our energies in this program toward retaining that record, just as we would in our private risk business. Due to lack of decision making control over this Federal program, we are not suggesting that a good comparison can be drawn between the operating expenses for the private vs. the government business we handle, but our study of the comparative figures as between Medicare B carriers seems to confirm our opinion that we are performing our contractual duties at a rate favorable to the government while providing the beneficiary with the prompt and complete service envisioned by the law.

By way of demonstrating this, our ratio of administrative expense to total benefits is well below the national average in spite of the fact that we receive a high proportion of unassigned claims and serve a large number of beneficiaries who are not residents in our state. National figure 8.40—Florida figure 6.86 (Oct. & Dec. '69).

Florida is a 700 mile long state with major economic and social contrasts which require unusual lines and methods of communications. For example, we have staff members of the utilization, physician, and hospital relations staffs in all major cities to provide immediate personal attention to problems of practitioners and beneficiaries alike. Also, in major cities, we have clerical staffs to handle the everyday questions of beneficiaries. These offices are in daily telephone contact with appropriate departments in our main office.

As an example of cost saving that was necessitated by the geographic area and the number of claims coming directly to us from beneficiaries, we use six full-time, wide-area, telephone service (WATS) lines for 8 and ¾ hours per day, to eliminate more expensive correspondence. In March, 22,792 calls were completed at a cost of $14,140 per month or, cost per call 61¢.

We believe improvements in cost can be made and some of the ways we are seeking to do it are by—

1. Use of claim receipt forecasting systems—to avoid overhiring or underhiring or excessive overtime.
2. Continued effort to improve individual performance.
3. Experiment with large clinics or medical complexes to produce data in a way that it can be used as input directly to the computer.
4. Introduce lower cost methods. Example: New microfilm production techniques to cut costs and reduce printed computer reports.

RECOMMENDATIONS FOR IMPROVEMENTS

These suggestions for changes are based on our belief that they will improve service to beneficiaries, not have an adverse effect on health care and will result in administrative cost savings to the program.

1. Base payments on a coinsurance amount only. The elimination of the deductible, combined with a coinsurance payment less than 80% would substantially reduce costs by simplifying the eligibility determination process.

2. A minimum dollar amount in contention should be set as the criteria for a Fair Hearing. No hearing for services not covered.

Such Fair Hearings in Florida cost about $200 on the Average and about 50% are questioning amounts of less than $50. A filing time limit of 90 days from notice of payment would be fair to the beneficiary and result in further saving.

3. At the present time we are not permitted to return incomplete, inaccurate or inappropriate claims to the sender for correction. If we could, it would substantially reduce administrative expense and, we believe, slowly improve the quality of claims.

4. We believe that the claim filing time limit should be no more than 15 months from the date of service. This is the limit in our own business and would reduce need to retain extremely bulky records for daily use, and avoid the need for complex research, and eliminate the inaccuracies resulting from the passage of time.

CONCLUSION

Gentlemen, this statement is necessarily brief, but we feel that it accurately portrays our activities and reflects our best efforts toward making this program work. We will be glad to respond to questions which you may have.

Thank you.

The CHAIRMAN. I would like to ask those witnesses who have testified to please make themselves available and come forward so that our staff can ask such questions as occur to them.

STAFF. Perhaps it might be best to have the Blue Shield people come up first.

The first reference we had this morning was when Senator Long referred to the followup in Florida on the physicians who had been paid, who had unusual kinds of practices, who were referred to the client for followup by Social Security.

Representing Blue Shield, in the report on this problem which Social Security prepared, we evaluated the quality of the followup by various Blue Shield plans in terms of their ability to properly review utilization and charges. Here is what they said. We won't identify the plans but these are some very large Blue Shield plans. These are current evaluations:

Despite repeated urgings, this carrier has been quite slow in producing meaningful reports. Despite repeated followup by Social Security Administration, later reports have not been prompt and have been general in nature.

This carrier's openly stated antipathy to this project was reflected in the quality of their investigations and reporting.

This carrier was reluctant initially to give any information regarding physician reimbursements. Their reports generally were not meaningful and conclusions not supported.

Would you agree that NABSP's position is that each Blue Shield plan should stand on its own and if it doesn't do a proper and thorough job for medicare it should be replaced?

Mr. KNEBEL. We get into a situation where NABSP has served the plans in providing assistance to them in a number of areas. In this particular area we generally had an authority only to urge the plans to investigate all of these matters thoroughly and that, I am sure, we did.

We subsequently were advised of the communication from Social Security that you have just reported, and have contacted each of these plans and are currently conducting an investigation. That information we do not have.

But I think, as was indicated in the testimony of Mr. Parish this morning, to get to your specific question of standing alone, the contracts for medicare part B are between the Social Security Administration and the plans and do not involve the national association.

Other national accounts of Blue Shield have utilized a different approach, as stated in the testimony. One of the plans generally serves as a control plan and assumes the responsibility for seeing to it that other plans participate.

In this manner we can share resources, bring technical assistance to bear on a weak carrier, and so forth.

I think this would be a better approach in medicare B than to take a position that a carrier standing alone does not measure up and should be dropped, because there is a tremendous investment both on the part of that plan and on the part of the Social Security Administration as well.

STAFF. I believe that in the staff report it was recommended that the Government cut its losses because there are usually other carriers willing to undertake these responsibilities. You feel that the control plan approach would overcome that individual "carriers' openly stated antipathy"?

Mr. KNEBEL. It has so proven in other accounts.

STAFF. Pennsylvania Blue Shield advocates underwriting of part B.

The elderly are a high-risk group, would you agree with that?

Mr. RINEHIMER. That is correct.

STAFF. Therefore, with my underwriting there would have to be a very high-risk factor, is that correct?

Mr. RINEHIMER. Yes.

STAFF. So the Government would be picking up an additional cost which it does not presently have.

Mr. RINEHIMER. At the present time there is no risk factor in it, that is right.

STAFF. On the other hand, if you did include underwriting for medicare, what would the reaction of your State insurance department be? Wouldn't that possibly place your regular Blue Shield business in jeopardy? That is, if you got an extremely bad year with your medicare population?

Mr. RINEHIMER. Yes. As a matter of fact, we would have to have discussions not only with the insurance department of Pennsylvania but also the providers of services as well. There was a question: "Would you mix the funds? Would you put our assets which we have against that underwriting?"

I am not sure whether there is any money available in Government circles for experimentation in underwriting or not. That is why I pose the question: Could we explore this with Social Security?

I am sure there would be pitfalls somewhere, but I think it deserves a good, hard look to see what could be done.

STAFF. We just wanted to get that risk factor in there.

By the way, underwriting would also make it somewhat difficult, wouldn't it, for, say, commercial insurance companies to compete favorably, where you are offering service benefits? That is just for the record.

Mr. RINEHIMER. This was contemplated. Say it was feasible to have it on an underwritten basis and it would be identified as a local program, then since we do have our participating doctors there would be a direct involvement of them in the program.

This is another thing we had in the back of our mind, where there is so much hue and cry about the doctors and do they care, is there some way that we can have a greater involvement of the providers of services?

I think when we have participating doctors, we do have that involvement.

I have here with me Dr. Sinclair, who is the vice president in charge of our medical affairs and who is working closely with it.

Would you care to speak about that, Dr. Sinclair?

Dr. SINCLAIR. Only to the extent that I think we need the total involvement of doctors int his whole program. We certainly need them in the utilization review activities.

I think that in order to obtain their full cooperation we have to include them in the planning for the other parts of the program.

I think Bob is right; that it is total participation that is needed. We have had no difficulty up to now in obtaining the complete cooperation not only of the Medical Society but the Osteopathic Association and the Dental Association, even though there is a very small portion of dental benefits in the program.

STAFF. Doctor, do you feel that the cooperation then is a product of really the structure of the program rather than the amounts it pays?

Dr. SINCLAIR. No, sir. I think the degree of cooperation is dependent upon the longstanding cooperation between the professional groups and Blue Shield, going back, in the case of the Medical Society, as far as 1940.

STAFF. No, I meant given usage of local mechanisms, such as Blue Shield, and a structure such as your organization, that the warm and cooperative spirit would still carry over regardless of whether medicare specifically paid the benefits under your highest contract.

In other words, if there were reasonable payments under medicare, would you still be able to evoke that cooperative response from physicians, or do you feel that the amounts involved help generate the warmth?

Dr. SINCLAIR. Well, I think a thorough understanding of the mechanism of payments is the key to it, rather than the absolute amount of the payment.

STAFF. That was the only point.

With respect to the operating plans in Florida and Pennsylvania, we have some questions as to your experience with gang visiting by physicians to institutionalized beneficiaries, overvisiting of beneficiaries, excessive usage of laboratory and X-ray services and charges, excessive injections—I think the Florida plan touched on the injections slightly—and fragmentation of fees. What has your experience been in those areas.

We will also ask those questions of the carriers and Dr. Melcher. We would like to know how you control these problems or what you feel should be done to control them.

Mr. RINEHIMER. The utilization department is under Dr. Sinclair's department. He will handle that one.

Dr. SINCLAIR. We had an early experience with gang visits which brought this to our attention right quickly.

We found that we had to establish guidelines to be used by our utilization department in evaluating claims for visits in extended care facilities. So we did establish those guidelines. They are not at the present time in our computer program. This is manual.

Any doctors whom we suspect may be performing gang visits we put them on a so-called flag status so all their claims are reveiwed prior to payment.

With respect to excessive laboratory and X-ray diagnostic work, for the most part, at the present time this is a matter of postpayment audit, and then identification of physicians who seem at least to be overutilizing these benefits.

Again, they are put on a flag status until they can be investigated. Our investigation will include the review of the claims that have been paid and once they are put on a flag status the prepayment review of claims as they come in, frequently then with referral either to our medical advisers or to the specialty adviser committees established by the Pennsylvania Medical Society, or it might be to the statewide osteopathic review committee in order to settle that point.

We had, of course, the same problem that has already been mentioned here, of the laboratory tests being billed on an individual basis, whereas they were performed on an automated laboratory equipment.

But we have gone out now to all the laboratories in Pennsylvania. We have gone to all the doctors who were high users of laboratories and found out where they ordinarily send their tests and what their arrangement with that particular laboratory is.

STAFF. Do you limit the payment for laboratory services which are performed outside the doctor's office?

Dr. SINCLAIR. Yes, depending on what the arrangement is and what we know about that laboratory's charges. We go directly to the laboratory.

STAFF. So in essence you are following, I believe, the American Medical Association's guidelines?

Dr. SINCLAIR. I believe so.

You had another part to the question and I don't remember it.

STAFF. Injections, excessive injections.

Dr. SINCLAIR. Again, we are doing this on a manual review basis, though we expect to have it computerized shortly.

STAFF. How about fragmentation of fees?

Dr. SINCLAIR. I am not sure I know what you mean by that.

STAFF. That occurs in surgical cases.

Mr. RINEHIMER. Itemization?

STAFF. That is right. Visits by the surgeon which previously were considered normally post- or pre-operative.

Dr. SINCLAIR. I think we handled that. As was said, we started a prevailing fee program prior to the medicare program and the doctors in Pennsylvania understood that their charges for surgery were to include what we call normal postoperative care.

This varied, depending on the type of surgery. In order to develop parameters we have used various relative value guides which do specify the number of days that are considered to be normal postoperative care, even though our own State medical society does not have such guidelines.

STAFF. How about Florida?

MR. HERBERT. I would like to have Dr. Shaar talk about the gang visit and the other situations.

DR. SHAAR. We have a computer utilization system which will detect gang visits or overutilization of visits in any location, excessive costs generated by too much laboratory or X-ray work.

All this material is produced on every physician in Florida and updated quarterly.

STAFF. When did you start using that?

DR. SHAAR. We have had this system since late 1968. We are using this as the basis for identifying possible overutilizing physicians of any specialty. When we identify a problem after study, if there is a serious problem it is to be referred for peer review at the local level since we found that support by a peer review committee is the best way to dispose of a problem.

We have this kind of support and we are encouraged at the results we have gotten so far.

STAFF. Following up on Senator Long's question: Of the 266 physician profiles which were sent to Florida for followup, on how many of those had you commenced action prior to referral from social security?

DR. SHAAR. Quite a few, the ones that we had already recognized as having serious problems. But I can't give you an exact figure. There were quite a few.

I would like to clarify another point. The 20 cases of fraud——

STAFF. Suspected fraud.

DR. SHAAR (continuing). That were under investigation, these cases were already developed by us with the cooperation of SSA and weren't necessarily the result of this question about the 267 physicians. This was an independent project.

From this 267 list there may develop——

STAFF. Social security relates 20 cases of fraud to the 266 which were sent you.

DR. SHAAR. There are some in that list, yes, but they were recognized not because of the request for study. It is coincidental that they are in that list. So we were looking for these problems from the beginning of the program and dealing with them on a manual study basis before we had a computer system to do this on all physicians.

We have not only finished the list of 267, but we are studying all physicians who have more than $25,000 in the medicare program.

STAFF. Are you studying those under $25,000?

DR. SHAAR. We studied the ones under $25,000 that had unusual patterns. The income makes no difference to us on which physician we would study. If the pattern is unusual, we would study it.

STAFF. And you are developing profiles on all the physicians under the program in Florida?

DR. SHAAR. Yes. We do this routinely. We have them now.

STAFF. On the other side of the coin, have you found beneficiaries who have overutilized benefits?

If so, in what ways and what do you recommend to prevent such situations?

I might preface this by saying that physicians have come in who are concerned about physician abuse but they are also concerned about beneficiary abuse—what they regard as beneficiary abuse—where physicians' offices are clogged, and so on.

Have you encountered that?

Dr. SHAAR. Yes, we have. We have seen not a great number but some forged doctor bills with altered dates. This was particularly true in the beginning of the program.

STAFF. Was this by the beneficiaries or by the physicians?

Dr. SHAAR. By the beneficiary.

STAFF. Or both?

Dr. SHAAR. By the beneficiary. It was not a great number, but it has existed.

Mr. RINEHIMER. I think that would be about our same situation.

Mr. HERBERT. We do feel, though, that there is a mechanism of communicating with the beneficiary that in our opinion hasn't been widely used.

You are sending social security checks to 19 million people every month, and certainly some message on being prudent on the use of benefits from time to time might be very well taken.

At the moment, the people have no direct communication. All they have is their red, white, and blue book that says, "You are going to get the doctor's usual and customary charge paid.

Yet, we have this inside limit, this freeze that is on. As far as I know, the beneficiary has never been told about this directly, face to face, or in a memo, a note, or other communication. It is all over the newspapers, but not directly from the SSA.

STAFF. The staff's understanding is that one of the reasons that SSA cannot do that is because every carrier system varies. For example, there are carriers who determine customary charges on the basis of charges to medicare beneficiaries only.

Mr. HERBERT. I am not referring to the specifics. I am saying that you could encourage the beneficiary to be prudent in the use of their benefits, regardless of who was the carrier involved, and that there are some limitations.

But this is resulting, as I mentioned in my testimony, in fair hearings coming up. They are just multiplying.

STAFF. I think what you mean is that you want a de minimis rule for part B hearings.

As the Senator said, it will be considered.

Mr. RINEHIMER. I was going to ask Mr. White a question.

Wasn't this discussed at one time of putting some fliers in the social security checks? I am not sure.

Was that discussed?

Mr. WHITE. Yes, it was.

STAFF. And that will deter beneficiary overutilization?

Mr. HERBERT. It won't do any harm and it may do some good. But more than that, it may prevent requests for a lot of fair hearings being asked for, beause I think they are being done out of their benefits.

Mr. RINEHIMER. We do think there is a potential here for further education, since SSA, I think, has the primary responsibility for educating the beneficiaries. After medicare part B got started in Pennsylvania, we held periodic meetings with the SSA district offices throughout the State and later when their funds were cut we brought them in in some regional meetings.

We went over the problems we had. They fed problems that they had to us. I think we learned through that much of what the beneficiary was doing, thinking, and the problems that he encountered.

I think that is an avenue that could be explored.

STAFF. Where you have detected possible fraud or abuse in medicare, have you had any difficulty in securing the cooperation of the Bureau of Health Insurance in making appropriate followup?

Mr. KELLER. We haven't had any problems in getting the cooperation on followup of the regional office. We have submitted 15 possible cases and five of these have been closed. Two have been referred to the U.S. attorney and eight are pending.

STAFF. Does that include the two which Senator Long referred to last July concerning gang visiting or overvisiting by two physicians which you people in Pennsylvania had referred to the Bureau of Health Insurance, you hadn't heard from for several months, so you figured if they were not interested you were not going to worry about it, and you went ahead and paid it? Do you recall that?

Mr. RINEHIMER. Yes, I do, and that was one of the cases.

STAFF. Were you finally able to get those closed?

Mr. RINEHIMER. Still pending.

STAFF. Beneficiaries complain to the committee that they are billed and payment made for services which are not provided. When those allegations are received they are sent up to Baltimore for followup but there are quite a few of them.

Precisely what procedures do you employ in Pennsylvania and in Florida to assure that services paid for by medicare are actually provided?

What verification procedures do you have?

Mr. KELLER. One of the procedures would be the supplying of an EOMB to the beneficiary on an assigned case.

STAFF. That is by regulation. I believe every beneficiary gets that. What have you as a carrier? Do you make any independent followup?

Dr. SINCLAIR. Yes. Every referral on that basis is sent to our utilization department where it goes through the regular procedure. An investigation is made, usually first by a field representative who visits with the beneficiary who has made the complaint, and attempts to establish the circumstances.

STAFF. Do you sample audit independent of the beneficiary complaints?

Dr. SINCLAIR. Yes, we sample on what our internal auditors choose to call a random scientific sampling, I believe is the term. Roughly, it amounts to about one in each 1,000 paid claims.

The incidence is a little higher on in-hospital claims.

STAFF. For a complete followup?

Dr. SINCLAIR. Right. This we call a routine audit.

STAFF. How about in Florida?

Dr. SHAAR. Every patient complaint is investigated and those that could possibly be fraud require us to notify our regional office of the possibility and in many cases we are asked to do investigation to determine if this is a serious question of fraud, in which case it is turned over to them for further disposition.

STAFF. The reason that question was asked is that at the last hearing of the committee, reference was made to a social security bulletin in which they complained that only one-third of the carriers and intermediaries regularly had any kind of systematic approach for doing sample reviews to determine that the services were actually provided to beneficiaries.

Again, you do not have a sample program but you react to complaints or suspected cases?

Dr. SHAAR. No. We have also done claims verification in the form of patient questionnaries on a sampling basis to see whether or not services billed were actually rendered.

STAFF. Do you do that regularly or just occasionally?

Dr. SHAAR. At one time it was done regularly. It is done on a spot basis at this time.

Mr. HERBERT. I believe we get an indirect sampling here because of our low assignment rate. Twenty-two percent of all of our claims need to be redeveloped because the information that comes in is incomplete.

This involves a contact with either the physician or the benficiary, and in some cases both, to find out what was the service that was rendered, what was the diagnosis, what are the service dates.

In other words, the poor claim quality results in an ongoing investigation of one out of every five claims. We are not happy about that in the cost but it actually acts as an ongoing review all the time.

STAFF. Quite a few beneficiaries have complained that their physicians are routinely charging them a separate hospital admission fee.

This is not for the initial physician visit in the hospital following admission. They have written in and said that Dr. X charged $35 for having his nurse call the hospital and arrange for admission.

Have you encountered that on any of your part B claims, in Florida or Pennsylvania?

Dr. SINCLAIR. We have not in Pennsylvania.

Dr. SHAAR. Seldom. I have seen it but it is rare.

Mr. HERBERT. Usually it is admitting history and physical as the reason for that charge and not an admission charge.

STAFF. Some of the bills indicate that. We wondered if it was presented in Florida and Pennsylvania, also.

Do you usually discuss with physicians the substance of specific cases where denial or reduction of benefits is made?

Mr. HERBERT. On an individual case?

STAFF. Yes.

Mr. HERBERT. Yes.

STAFF. Does the practitioner have an opportunity to discuss the issue with a physician if he wants to?

Mr. HERBERT. The beneficiary?

STAFF. No, the physician. Where you question the medical necessity of a service, for example, can he discuss that with your medical director if he wants to or other professional personnel?

Mr. HERBERT. Yes, he can do that, or he can appear before the Claims Committee that reviews that, or he has the right to appear before the Board.

STAFF. Can a physician appeal your final determination as to medical necessity and reasonableness of charges?

Mr. HERBERT. Not beyond the Board level.

STAFF. Not beyond the carrier level?

Mr. HERBERT. Well, yes, that is correct.

STAFF. Do you think he should be able to do so? Do you think a mechanism ought to be established?

Mr. HERBERT. Many feel quite vocal about that.

STAFF. That is why we are asking the question.

Mr. RINEHIMER. I was going to ask Jack if there were any unfair hearings, if he had any doctors request fair hearings?

Mr. HERBERT. Yes, we have had doctors request a fair hearing. When our fair hearings start out with a statement that "Anything you say might be a Federal offense," and so on and so forth, he says, "You are bludgeoning me already. I can't even get a word in edgewise."

If such a procedure were to be set up, a further appeal, I would suggest that a minimum amount of money be tacked onto it, like $200 or $300, something like that.

STAFF. What specific procedures do you employ to assure that unnecessary medical services are not being paid for by medicare?

We are somewhat familiar with Pennsylvania so this is mostly for Florida.

When did you start such activity and what have been the specific results? That is, your procedure with respect to detecting medically unnecessary services, when did you start, and what have been the results?

Dr. SHAAR. This has been done from the beginning, more efficiently now than in the beginning. But it has always been an attempt to identify the physicians who are routinely performing unnecessary services. This is the main function of our utilization department.

Overutilization is dealt with by flagging the physician, reviewing all of his claims, and if this is a problem, referring him for peer review and some kind of corrective measures to eliminate the problem.

This is a continual process that has always been done but not efficiently until a computer system was available.

STAFF. As long as we have you here and you represent Blue Cross also, do you go into the medical necessity of ancillary services provided in hospitals?

Dr. SHAAR. Yes.

STAFF. Have you questioned any?

Dr. SHAAR. Yes.

STAFF. You have?

Could you provide for the record examples of what you have done there? There are Blue Cross plans which, according to the HEW auditing agencies, have never questioned a single ancillary service.

Dr. SHAAR. This is for Blue Cross, not part A?

STAFF. Part A, yes, sir.

Dr. SHAAR. We have done it in both part A and Blue Cross.

STAFF. We are talking about the specific services, not the institutionalization of the patient, but the services provided while he was institutionalized.

Dr. SHAAR. Under part A?

STAFF. Yes.

Dr. SHAAR. Yes, we have.

STAFF. In hospitals?

Dr. SHAAR. Yes, and we could supply specific hospitals if necessary.* It has been done.

Mr. HERBERT. You will remember we suspended payments to a hospital which I think produced some shock waves throughout the country.

STAFF. Didn't the FBI stimulate that?

Mr. HERBERT. No, sir. We were the ones who put the finger on that. You are thinking of a hospital in a different part of the State which we were not the intermediary on.

STAFF. I see.

This question is for NABSP or any of the Blue Shield people who care to answer it.

We have heard that some Blue Shield plans now underwriting customary and prevailing coverage in their regular business are concerned about rapidly rising charges and costs and are considering additional limitations on customary and prevailing.

Is that information accurate? That is, specifically, are Blue Shield plans which presently underwrite customary and prevailing considering further limitations?

Mr. KNEBEL. Your information is correct. When you say "further," it means beyond what has been decided upon as policy in these programs.

Therefore, they are in an experimental study stage where various mechanisms, as was pointed out in the testimony, relate them to some external index.

The trends in this area of the economy would be tied to some external index which would relate to other components.

STAFF. Relating allowable changes to various indexes?

Mr. KNEBEL. That is correct. They are viewing this both in the overall cost of a program and also as far as an individual physician.

STAFF. Why do they feel the need to apply limitations?

Mr. KNEBEL. Most Blue Shield plans feel that they have reached the point where they have correct administration of the usual and customary program today and must address themselves to where that program is going to go into the future.

They want to keep it a correct program. Frankly, there aren't many alternatives. So now is the time to plan for cost containment over a longer period.

STAFF. Do you feel that further cost containment is necessary?

Mr. KNEBEL. Absolutely.

STAFF. In that context, we have a related question. There has been quite a bit of talk of gearing various payment levels to rises in the consumer price index or related indexes.

Based upon your experience, does it make sense to authorize a blanket increase based upon the consumer price index in all allowances, for all benefits and all services covered in your program, or would it

*At presstime, Aug. 10, 1970, the material referred to had not been received by the committee.

be preferable to authorize a certain level of increase allowing for differentiation?

That is, where conceivably the cost of an office visit could rise at a rate greater than the CPI but due to changes in medical technique, a given surgical procedure could actually be reduced in cost, does it make sense to increase across the board?

That is the question.

Mr. Rinehimer. We already have the directive, as I pointed out in the statement.

Our Commissioner recognized this, I think, when he said the overall. In other words, for home and office visits, it could conceivably be increased more, where perhaps, as you refer to a surgical procedure, it shouldn't be increased that much.

I think you have to do it on a selective basis.

Mr. Parish. I think we would agree with that position.

Mr. Herbert. Yes.

Staff. Are you gentlemen familiar with SHMOO, the supplemental health maintenance organization option proposal? Is that correct?

Mr. Knebel. Very close.

Staff. It is a part C proposal of the administration which is being bandied about.

Have you people any opinion on that as yet?

Mr. Parish. I can open the comments on it. The national association, to begin with—and I believe most Blue Shield plans agree with this position—is encouraging all plans to experiment in various forms of delivery of health services.

We have encouraged investigation of prepaid group practice, for example, experimentation in this, and at least four of our plans are currently doing this.

We would welcome various forms of health care delivery to a point where, in the final analysis, the consumer is the one who makes the decision and we offer him a choice on which to base that decision.

That could include a variety of forms, including fee for service, fee for service group practice, prepaid group practice, the whole gamut of delivery.

Until we do this and make that choice available, we aren't going to know the answers to some of the problems we are all trying to solve. We are definitely encouraging experimentation in this area.

Staff. We wanted to ask you a little more about the staff recommendation on revision of part B in medicare.

Pennsylvania, evidently, is less enthusiastic about it. Basically, what the staff recommended was that regional schedules of allowances be set up for the nine census regions based upon what an advisory group of private actuaries and underwriters determine related to coverage in the area. Within that framework locality differentials and specialty differentials could be worked out by the various specialty groups and State medical societies in each of those regions.

The staff proposal also contained the concept of participating physician. That is "in or out." A physician could opt to be a participating physician in which case he agrees to accept the allowable amount shown on the schedule as his full charge for all of his medicare beneficiaries.

Otherwise, payments would be made directly to the beneficiaries, as opposed to the present "I will take the assignment because I don't think I can collect from this one and I will bill this one because I think I can collect maybe a little more,"—that kind of thing.

The $50 deductible would not apply to services rendered by a participating physician.

The $8 premium, it was felt, could be raised by Congress from time to time.

This framework is set to show where we are, and to then ask your comments on it.

Do you think it is feasible?

Mr. RINEHIMER. One of our problems, sir, in looking at our own State of Pennsylvania is we studied about 163 hospital service areas. That was devised by the Department of Public Health and Welfare.

They grouped these various hospital service areas. They looked at the banking and the trade, where they got their care and so forth. They varied considerably.

What we found in trying to develop a new fee schedule, which we never did do, was that if you come up with a fee schedule, like for a census region, it will be too high for some doctors and too low for others.

Where it is too low for others, I think the doctor's cost is shifted to the patient. But where it is too high for the doctors, where it is more than what he is getting now, it is going to set a new floor for them, so you will be putting out more money there.

STAFF. You could have the locality differentials. The point is, for example, that in Pennsylvania, your A contract, as I understand it, is also used for medicaid.

I think they use it to pay for medicaid in Pennsylvania on a statewide basis. Apparently, the State is certainly satisfied with it. They don't want to go beyond it.

There are a fair number of Blue Shield plans which have had effective scheduled allowance statewide contracts. Or isn't that true? Are all the scheduled allowance contracts offered by Blue Shield inadequate and ineffective because of those same conditions you described?

Mr. RINEHIMER. We had trouble with the free schedules because of the limited service benefits and the fee schedules are old.

STAFF. Are you talking about people above the service income limits?

In the one case you gave the argument about the problem with physicians' charges varying and in the other you talk about partial service which really relates to the income of the policyholder, the subscriber. Which was the problem?

Mr. RINEHIMER. Our big problem was with the person who didn't qualify for service benefits.

STAFF. Because then your contract was an indemnity schedule for him?

Mr. RINEHIMER. That is correct.

STAFF. But he was entitled to exactly the same dollar amount as the subscriber who qualified for service?

Mr. RINEHIMER. That is right.

STAFF. But, again, you would say that, in effect, then, Blue Shield scheduled allowance contracts have been essentially deficient because of those points?

Would you agree with that, Mr. Knebel?

Mr. KNEBEL. I think when he is referring to the over-income subscriber, which he indicated, the burden for the difference between the amount of the fee schedule payment and the usual charges of the physician which varied from area to area became the burden of the patient.

STAFF. Are you saying that many of us who have Federal employees coverage here are inadequately covered by Blue Shield because we are over the income limits?

Mr. KNEBEL. If you are over the income limit that we have here in the District in the Federal employees program, you are subject to an additional charge between the amount payable and the amount of the physician's usual charge.

STAFF. And you are saying that that type of coverage is inadequate?

Mr. KNEBEL. In the District, on this particular program you have the ability to absorb that additional charge into the supplemental benefit areas and get an additional benefit beyond what the under-income subscriber would have received.

STAFF. You have a corridor deductible to meet first.

Mr. KNEBEL. Yes, but that corridor can be met by a wide variety of expenses, not solely by the differential.

STAFF. Do you still claim that approximately one-third of Blue Shield subscribers today have customary and prevailing coverage?

Mr. PARISH. That is correct. Roughly 20 million.

STAFF. So two-thirds of the Blue Shield subscribers have a scheduled allowance contract, the majority of which are service, some of which are indemnity, is that correct?

Mr. PARISH. That is correct. But I think it needs further explanation, in that the move to the usual and customary fee concept has made that 20 million in a period of something less than 5 years, which would indicate a substantial trend.

STAFF. Didn't national account contracts trigger that?

Mr. PARRISH. National contracts and large local contracts, yes, because of the ability to purchase, obviously. It costs more.

STAFF. The staff has had some Blue Shield officials come in from time to time and candidly say that in their opinion they felt that medicare triggered the rapid rise in demand for customary and prevailing coverage and forced Blue Shield to push for that.

Mr. PARISH. I don't think there is any question but what there was a substantial impetus created by medicare. On our being pushed, I wouldn't say so, because we had already started a rather substantial experimentation. We had a rather substantial experimentation in this area with the motors industry, a very substantial segment of the employed population being moved into this area.

STAFF. We were wondering whether there had been a rebuttal by Blue Shield to something which Senator Long stated at the last hearing.

He quoted Prof. Max Shain in his opening remarks—this was in February of this year—on the outset of medicare in 1966. It goes like this, quoting from the February 25 hearing volume, at page 2:

Senator LONG. Let me illustrate the high price paid by Medicare. Professor Max Shain of the University of Michigan was an adviser to the Michigan Insurance Department on new contracts to be written under Medicare in that State.

The Michigan Blue Shield man—Medicare's agent—filed a rate contract for Medicare which, according to Professor Shain, was based on physician's fees that were 10 percent higher than Blue Shield paid for its highest income subscribers.

When Professor Shain pointed out what he believed to be a clear violation of the law, he reported he was told by Blue Shield:

"Well, it's true that most of our elderly members have very low incomes, but you just don't understand the new situation. The subscriber for these old people is now the U.S. Government. Uncle Sam, you know, and he has a very high income, in the billions. The social security people have already approved this interpretation."

Did Blue Shield get any comment on that from Michigan or anywhere else?

Mr. PARISH. In the first place, we did not see this thing you are reading until Friday night. We have had no opportunity to even discuss with Michigan Blue Shield.

STAFF. The remarks were available to Blue Shield's Washington staff in February.

Mr. PARISH. This, as I say, was received in our office only Friday evening. Obviously, Michigan is the only organization to respond. I would congratulate the Professor on an excellent memory for what he said.

We will make certain that Michigan Blue Shield sees this and their response, I am sure, will be forthcoming.

STAFF. Will you see that they submit a response for the record?

Mr. PARISH. We would be very happy to.

(The following was subsequently received by the Committee:)

MAY 8, 1970.

Hon. RUSSELL LONG,
Chairman, U.S. Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: During a recent meeting of the U.S. Senate Finance Committee on the matter of medical care costs, particularly as they relate to government programs, certain of my associates in the Blue Shield field were in attendance when a reference was made to Michigan, and to the Michigan Blue Shield Plan.

I feel I have some sense of the importance and substance of the deliberations of your Committee and, for that reason, am very concerned that the aforementioned reference is completely baseless and untrue.

I have spoken to all of the Michigan Blue Shield officials who might have had contact of any kind with the gentleman who purported to have had the conversation referred to in your statement.

No conversation took place.

No such comment was made.

While it is true that charge patterns of the past made by physicians often relate to patient or subscriber income, the Medicare reasonable charge concept specifically excluded income as a factor in developing charge patterns.

Physicians' customary charges often exceeded income limit in Blue Shield schedules.

That could explain the reason why charges to some Medicare patients might have exceeded the payments made by some Plans whose scheduled payments were lower than normal charge patterns, because those schedules were geared to income.

In Michigan we are very sensitive to the degree with which we exercise control on costs, within the law and Social Security Administration regulations, on the funds we disburse for Medicaid and Medicare.

For your information, I am attaching the results of a study recently made showing how average charges under the Medicaid Program compare to charges under our regular programs during the year 1969. As you will note, in every case the charges under Medicaid were lower than those under our regular programs.

Respectfully,

JOHN C. MCCABE.

COMPARISON OF AVERAGE CHARGES FOR MEDICAID AND MICHIGAN BLUE SHIELD MVF PROGRAMS FOR SELECTED SURGICAL PROCEDURES MAY 1968 TO JUNE 1969[1]

Code	Description	Average medicaid charge[2]	Average Blue Shield charge (MVF)[2]
	Surgery:		
5611	Excision of lens	$364	$399
4321	Electrocoagulation prostate	369	402
3631	Inguinal hernia repair	178	189
3515	Cholecystectomy	327	337
4311	Prostatectomy	378	405
3375	Hemorrhoidectomy	147	166
0111	Bronchoscopy	88	95
2470	Radial mastectomy	404	407

[1] The above identical procedures were presented to the Senate Finance Committee comparing Michigan M-75 fee schedule payments based on income to Michigan medicaid payments based on a usual, customary, and reasonable reimbursement concept.

[2] Average medicaid and MVF charge data is for specialists in Wayne, Oakland, Macomb, and Washtenaw Counties. This geographic area accounts for the majority of all medicaid payments

Source: MVF prevailing computer run processed August 1969.

Staff. NABSP testified in 1965 that it had extensive data on physician customary charges. The information the staff has indicates that the statement was inaccurate. As a matter of fact, during questioning of the administration witnesses in February, Deputy Commissioner Hess said that it was an inaccurate statement by Blue Shield in 1965.

Exactly what data did you have? Did that extensive premedicare data serve as the basis for payment by Blue Shield plans under medicare starting in 1966?

Mr. Parish. I would like to put this comment in the proper context. The context was the proposal we were making at that time for a service contract based on a $7,500 income level and a fee schedule.

I would refer the details of development of these data, the test of performance which we discussed in exhibit E of that attachment that we submitted, and the information that was generated by that study to Mr. Knebel who was responsible for the study at that time.

Staff. We promise not to belabor this, but you refer to this as based upon the FEP program.

You said in 1965 that the Blue Shield plan schedules generally reflected the prevailing charges in the community. You said that this was true to an increasing extent, and so on, and so forth.

Mr. Parish. I think it has to be made clear here that we are not using "prevailing" in the context you are using it now. We did know what the going charges were, but we were not talking about profiles of physicians at that time.

Staff. You said that the Blue Shield schedules reflected the prevailing charges in the community.

In your comment in 1965 to the committee, on page 532 of the printed transcript all of this was presented in the context of your overall coverage not just the FEP program, because your response to question 8 in which the previous quote appears is prefaced with the statement: "The dominant feature of Blue Shield's offering to the American people." Most of the American people, and the staff has done a lot of research, are not Federal employees.

Mr. PARISH. Well, I will concede that. There is no problem there.

Again, we were talking about a program in which we were attempting to influence legislation at that time.

We said that we respectfully disagreed with the approach which the Congress was taking at that time. We thought that the method that was being used, and the front-end deductible—as it emerged—was not right, and we were free in our predictions of the difficulties which subsequently occurred.

STAFF. We really don't want to labor it, but those 1965 statements were not really advocacy points. Those were presented as statements of fact in terms of Blue Shield's knowledge and capacity, and regardless of what program was ultimately established, those statements of facts presumably were relevant to any kind of program and related to what capacity you might have had as carriers. It seemed to argue Blue Shield plan capacities as carriers, in terms of the determination of customary and prevailing charges.

The staff's point is very simply that there just were no adequate data available when medicare started; that the data which has been maintained as being available were not available in fact, and that the medicare payment structures have been built on an inflated base from the beginning.

That is why the staff proposed the part B change in its report.

Dr. SINCLAIR. May I comment on a previous question? You raised the question of making medicare a participatory program in which the physician would agree to participate not on a case-by-case basis as he does now but on an outgoing basis.

I think the committee ought to be aware of the fact that participation, at least as it applies in a service benefit Blue Shield plan, is a two-way street. It is not simply asking the physician that he accept the payment in full, in return for that, he has some voice in the affairs of the organization, at least so far as offering advice, medical advice, with regard to benefits, being consulted with respect to changes, and so on.

I wouldn't want the committee to feel that simply by saying that there will be participation, that participation will be effective. It is something that a Blue Shield plan has to work at all the time.

It is not quite as easy as the words themselves might imply to the committee.

STAFF. Isn't it true, however, that a fair amount of participation is engendered by the avoidance of collection problems and billing problems? I thought that was true.

Dr. SINCLAIR. This is undoubtedly a factor.

The question is, though, how much of a factor?

STAFF. The aged are kind of a tough group to collect from, actually, Doctor, and I think you will concede that. The AMA News has had letters of complaint from doctors who do not accept assignments where the payments were made directly to the beneficiaries.

Dr. SINCLAIR. There is also a philosophical aspect and I think the committee ought to be aware of this. It is not quite as easy as it might sound sometimes.

STAFF. Nor as difficult.

Mr. HERBERT. Fifty percent of the doctors in Florida don't feel there is any problem in collecting. They don't take assignments, period.

Just giving them a lot of money didn't encourage them to participate. This was the point, I think, that Dr. Sinclair was trying to make.

STAFF. A majority of physicians do not participate in Florida?

Mr. HERBERT. They do participate in Blue Shield, but they are not participating in medicare because they don't take assignments.

STAFF. What proportion take assignments?

Mr. HERBERT. Forty-seven percent are taking assignments. And if you include the 1554's, which are the hospital-based physicians. That comes to 53 percent.

STAFF. What portion of the 53 percent of your physicians take assignments all of the time?

Mr. HERBERT. That is bills, I am informed. It is a count of bills on which assignments or nonassignments are made.

STAFF. You just have to pick out which of those are in the high incomes, to make your point.

In other words, the $25,000 or over group are not represented.

Mr. HERBERT. I think there are some in it and some that are not in it. I don't think this is a factor.

On participation and involvement, when you are talking about fee schedules and other developments, the success of any program, whether it is a fee schedule program, if it is dealing with physicians, really goes back to the amount of physician involvement and the development of it.

STAFF. Physician involvement is easy and physician development is easy. I think what you are talking about is the amount of payment.

Mr. HERBERT. No, it is not easy. Doctors in Florida are not at our back pushing us all the way. Yet, these are the ones that would provide them, so it would seem, with the most money.

STAFF. But we are paying it anyway.

Mr. HERBERT. You are paying what the law and the regulations, as we interpret them, agree to pay.

STAFF. You say the law says payments on the basis of customary and prevailing?

Mr. HERBERT. That is our interpretation of what the law says.

STAFF. Then there is no point in belaboring that. I think the staff report says the law provides for consideration of customary and prevailing, not payments on the basis of customary and prevailing.

Do you feel if there are 60 percent, 70 percent, or 80 percent of medical payments made in an area under Blue Shield contracts, such predominant payment levels could have been used as valid indicators of what was customary and prevailing?

In other words, in determining customary and prevailing charges, if you ignored 70 or 80 percent of the physician's bills paid under Blue Shield service contracts, could you determine the customary charges based on the other 10 or 20 percent?

Mr. KNEBEL. If this were a Blue Shield program which had a single program, which had been updated periodically and was current at that time, it probably did. If they still had a program on the books that was 15 years old. I would doubt if it would have any relationship to prevailing charges.

STAFF. You have had a chance to study the table in the staff report comparing Blue Shield's maximum payments under its most widely

held contracts with average medicare payments for selected procedures.

How many Blue Shield contracts issued years ago have not been changed at all in terms of premium increases or benefit changes within the structure of the contract?

You don't have to get the specifics. This is a general question.

Mr. KNEBEL. I know only those in our Part B carriers that were cited in the staff report. I know the history of those programs.

STAFF. If you want to put that into the record, it would be appreciated. It would be significant, for example, if a policy issued in 1955 had not had a single change in either benefits or premium charges.

Mr. PARISH. I think this was true of Alabama. It was not upgraded in terms of the fee. They may have had a change in the premiums.

Mr. KNEBEL. The particular one in Alabama actually was revised in 1956. That was the latest revision.

STAFF. Alabama was a very atypical, I think you will agree. The staff went over those Blue Shield contracts and 40 of the 57 are on a service benefits basis.

Mr. KNEBEL. It was a 1946 program.

STAFF. I think we might as well go to the carrier group.

One of the points made in the staff report, and a major point, was the unevenness, the dissimilarity, in performance by carriers and intermediaries.

Our information is, for example, that when medicare started or was to start, Prudential considered and then rejected the idea of surveying physicians as to their customary charges.

Mr. WHITE. That is correct.

STAFF. Why?

Mr. WHITE. It was my decision. I have to go back in my own personal experience, in my own business life. I, at one time, worked for the Wisconsin Physicians Service at the time the CHAMPUS started, and I was relying on the CHAMPUS experience, that where you ask physicians questions about what they charge or where you publish a schedule, everybody goes up higher; and if you do not publish a schedule, do not emphasize the point of asking, "What do you charge?", you save money.

So we decided to rely on our own major medical experience in New Jersey as the basis for the beginning of medicare rather than to ask the physicians.

I think it is human nature that if you ask someone, "How much do you charge," you tend to put down what you would like to charge rather than what you would actually charge. Therefore, you get an artificial inflation.

I made the decision that that was too much of a risk to take and we wouldn't do it.

STAFF. That is the so-called anticipatory bias?

Mr. WHITE. Yes, sir.

STAFF. The reason the staff wanted to ask you that question was because that type of survey was precisely the method used by Pennsylvania Blue Shield in developing a payments basis for medicare. They surveyed physicians in the State.

Mr. WHITE. As I said, personally, I don't agree with that approach.

STAFF. Dan Pettengill, of Aetna, said in 1965, that most physicians,

in Aetna's experience, did not actually use a consistent schedule of fees. This is up to and prior to medicare, not necessarily today.

They did not necessarily use a consistent schedule of fees but varied the fees from case-to-case.

Under such circumstances, would you think it natural for doctors to seek to have their highest fee accepted as customary for medicare purposes?

Mr. WHITE. I don't really agree with that because of what we actually found in our experience. As I mentioned, we took our major medical experience as a base. I will tell you frankly how we operated. We had to start some place. We took our major medical experience to be what we considered the prevailing cutoff. We converted it, in effect, to a value schedule, and lowered it as our cutoff for medicare, and the fees that actually came in were actually below that, and then we lowered them again.

I think one of the reasons was because with a lot of the older people, oldtime patients and physicians, the physicians over the years had raised their charges, but had not raised them for their old patients as much as for their younger patients.

In our own business we were getting experience from employed groups with fairly good incomes. Therefore, our medicare experience was actually below our major medical experience.

STAFF. Is medicare gaining on you now? Do you hear footsteps behind you?

Mr. WHITE. The whole thing is going up. We have a hard time staying even. But still, on our sampling we do in our business, we still find that our medicare experience is below our major medical experience in New Jersey. Maybe it is because of New Jersey, the types of groups we have, the higher income. I don't know.

STAFF. You had a greater population on which to base your interpretation of charges than some of the other commercials who had small States, say a Connecticut-based company which picked up a small State out West, that kind of thing.

It was very difficult to see how they could determine what the customary and prevailing charges were in those areas.

Mr. WHITE. You are right, we did happen to have a very favorable situation, because in New Jersey we had a lot of major medical coverage.

STAFF. Did you want to comment on any of the questions that were asked? This is a sweeper. Do you want to comment on any of the questions that were asked Blue Shield?

Mr. WHITE. You asked a lot of questions.

STAFF. Was there anything there that struck you as particularly relevant to your own experience, before we get into some of the specific questions for you?

Mr. WHITE. Yes, especially on the Blue Shield fee schedules. I guess maybe in this way perhaps I am a competitor to something I have been arguing with Blue Shield about for years, that their fee schedules do not reflect the prevailing charges.

In fact, long before medicare, I have been arguing with physicians on this very point.

If you will remember, Senator Ribicoff asked me the question about lymph extraction. Our average is 247.

For years, we have been paying more under major medical. I have been asking the doctors how they justify this. Two men live side by side and each makes $7,500 a year. In Blue Shield you charge $275, but a Prudential policyholder you charge $400; it is the same income. There was never a satisfactory answer.

In fact, I am not so sure that they weren't collecting more than $275 in many cases. But this has been a long-going battle.

I have to agree with what they are saying that their schedules really don't reflect prevailing charges.

STAFF. There are those who also say that major medical is inherently inflationary, also.

Mr. WHITE. I am afraid from our own experience perhaps you are right. In fact, again, there has been a lot of criticism of the operation of the insurance companies and medicare, but I have to be very candid with you and say that over the years, the last 4 years, of medicare, we have learned to be a lot tougher than we were in our own business, and we are getting tougher in our own business because of this. Because we were trying to do a good job for the Government, we really began to bear in on some of these situations that we weren't doing, very frankly, in our own private business.

STAFF. Do you think that private insurers have been inhibited to any extent in dealing with physicians and others because of their nonmedicare relationship with doctors in terms of workmen's compensation, the sale of private health coverage, homeowner's coverage, and their general business?

Mr. WHITE. Do you think that inhibits us in medicare?

STAFF. Not necessarily in medicare, but I mean in terms of having effective and forceful utilization review.

Mr. WHITE. I will tell you what happens in our private business that is very difficult to deal with. Most of it is bargained, and the people feel that they are entitled to the full benefits of the contract.

You are in a very difficult position to cut fees or to police utilization.

On the other hand, in medicare, we are bound by the law and regulations, and we aren't inhibited by these bargain situations. We are cutting a lot more fees and policing utilization more than in our own private business.

The interesting thing is that the criticism in the newspaper is that they are overpaying in medicare. We are cutting a lot of fees. The complaints we are getting through the Congressmen from New Jersey is from people saying or complaining that we are cutting; we are not allowing these over-utilization cases and we are cutting fees.

The complaints are mounting because we are policing this thing.

STAFF. Do you think an amendment is necessary?

I am not sure whether the administration has this in their cost effectiveness proposals. Is an amendment necessary to permit the cessation of payments under part B where you cease payments for covered care under part A?

Mr. WHITE. It is in the cost effectiveness.

STAFF. That takes care of that.

Mr. WHITE. But that is a problem, too, which I have raised with the administration. Again, what they were talking about in their proposed amendment is an effective black list of physicians.

This is the point I have been trying to make earlier in the day, that this is an insurance program. We don't have contracts with physicians. You end up with the beneficiary on the spot. Believe me, I hold no brief for a physician who is abusing a program.

But the problem I raise is the administrative problem. Suppose we say we are not going to pay benefits for Dr. Jones. How do we notify all the 650,000 people in New Jersey? They can go to Dr. Jones, pay the bill and come to us and we say, "Sorry, we are not going to give you any benefits because he is on the backlist."

This leaves the beneficiary in the hole, and that is the fellow I am concerned about in this kind of a situation. I hold no brief for the doctor at all, but I don't know how to administer it as it is now proposed in the cost effectiveness amendments.

STAFF. We asked the question of the Blue Shield people as to whether they thought it would be appropriate for physicians to be able to appeal from a carrier's final determination.

As a carrier group, obviously, you haven't considered that formally. But speaking for Prudential or Mutual of Omaha, have you a feeling about that?

Mr. PATTERSON. Are you referring to a formal appeal?

STAFF. That is right, beyond the carrier's final determination.

Mr. PATTERSON. I think the physicians prefer to discuss or appeal any judgments that the carriers make with which they do not concur to their own medical review county peer review society or the State medical association.

STAFF. We have had physicians come in here who say, "There ain't no peer in my society," particularly in the case of specialists.

Mr. PATTERSON. I think this is true in some cases, particularly in predominantly rural States where there really aren't enough physicians in an area.

STAFF. And they object to the determination of the finding of the carrier. Now, what do they do? The doctor has no recourse under present law, does he?

Mr. PATTERSON. I believe that is correct. But in our particular area, the State medical association house of delegates is given the policy committee, which are the five presidents, current president, president-elect, and the three immediate past presidents. They have the authority to adjudicate any of these cases.

These men were elected by the physicians and they are highly respected. We have had no problem in this area because they accept their determinations.

Mr. WHITE. I would like to respond to that question.

I personally do not want any more appeal beyond the carrier. I think we have taken on the responsibility, and I think you expect us, and the Social Security Administration expects us, to administer this program. I think we are doing a good job.

We have practicing physicians as consultants. If a physician accepts an assignment, he has the opportunity for a fair hearing. I don't really believe it ought to go beyond that. It will only increase the cost of the program and maybe satisfy one or two doctors.

I would like to tell you of an experience we are having right now on part A. We are trying our very level best to administer this most

difficult benefit for extended care. We are being overruled by hearing examiners in HEW.

It really is making it most difficult for us because we are doing all we possibly can to interpret this benefit. Believe me, we have doctors review these things over and over again and say, "We are not going to pay the benefit." It goes to a hearing and the hearing examiner overrules us and the word spreads. All you have to do is complain to the hearing examiner.

Our whole utilization control goes to pot.

STAFF. I suppose it is time for us to get a little specific. Mutual of Omaha, as I understood it, was under a ban from social security for a while in terms of being authorized to take on any more ECF's. That is, you were not permitted to take on any more extended care facilities for a while.

Are you familiar with that?

Mr. PATTERSON. Yes, sir, I am.

STAFF. Has that been removed?

Mr. PATTERSON. This existed for a very short period of time. When we received notification of this, I visited with the Social Security Administration and outlined the things we had done and were doing actually before the program validation visit that resulted in this, and emphasized the progress and activity that we were engaged in, in the audit area.

We have always pursued this very aggressively because we feel it is in the best interest of the Government as well as the provider, to know where he stands in the program. They are not used to working in cost reimbursement programs. This activity that we were engaged in was put in writing to the Bureau Director and he agreed to lift the suspension.

STAFF. Have you seen any of the program validation visits which have been made in the last 6 months to over 40 extended care facilities around the country?

We are speaking, for example, to some in California which Mutual of Omaha serves.

Mr. PATTERSON. In the past 6 months?

STAFF. Yes, June 16–20, 1969. That is about 8 or 9 months ago. There were some more in May 1969 in Oregon. That was almost a year ago.

Mr. PATTERSON. Yes, I am familiar.

STAFF. And in Texas, in Dallas.

Mr. PATTERSON. Yes.

STAFF. You have seen these reports?

Mr. PATTERSON. Yes, sir.

STAFF. Have the deficiencies which they reveal been corrected?

Mr. PATTERSON. Yes, sir.

STAFF. They were quite serious.

Mr. PATTERSON. Sir, I wonder if I could make a point, too, at this time, with respect to the extended care facility benefit?

This was a complete renew concept that was given birth by the medicare program, and at the time, there was no organized body of information or knowledge with respect to the benefits covered by medicare.

For example, not only the benefit itself but some of the charges which are billed, the ancillary services, really prior to medicare the amount of physical therapy, occupational therapy, speech therapy, drugs given in an extended care facility environment—there really wasn't any feel for what is normal, what is the average amount.

So as we look back, the benefit of the time that has passed with our experience, we can see that some bills were paid which should not have been paid, and are not being paid today.

But I would hope there would be some appreciation for the fact that with this particular benefit, and I think the same is true for a number of other benefits.

STAFF. Do you mean at one time you were paying all of the bills?

Mr. PATTERSON. No, sir. In the beginning of the program there was a great thrust, great pressure, put on the intermediaries to get the paper moving to pay these claims.

I think at this time, again with the lack of experience, the knowledge, the information, which would have been most helpful at that time, as I say, some care was undoubtedly paid for that would not be paid for today.

STAFF. Do you think that the competition of various organizations for service as intermediary may have contributed to a more relaxed attitude in scrutinizing the claims? I am not speaking of Mutual of Omaha, particularly.

Mr. PATTERSON. I don't think so. In all candor, I don't think this was the case at all. Mutual of Omaha has never been interested in serving any provider who feels he would get a different type shake from us than he would any other intermediary, and they are so informed on any switches currently, anyone who comes to us, nominates us, to provide our services.

I wonder if I couldn't make this statement, too: I was a little surprised at some of the chuckling when reference was made to the insurance company intermediaries and carriers particpating in this on a no-cost basis. Really, paying health claims is our business.

It is true that we don't like to do it just for love, without any reimbursement. But since it is our business, we feel we should be active in it.

I know in our own case the question came up at a board of directors meeting. I am informed that General Doolittle, who is a board member, asked one question. He said, "Is this the law of the land, medicare?"

Obviously, the answer was "Yes."

And he said, "Well, I think we should participate."

So not with the intention of waving flags or trying to make it appear that we are overly public spirited, I think certainly this was the motivation of a good many companies, that when the Government asks you for help where you have some experience you shouldn't be looking the other way, even though it is on a no-cost basis.

STAFF. The staff report recommended in the simplest terms that the Government get rid of the inefficient carriers and intermediaries and pay for what it gets from the good ones.

Mr. PATTERSON. I don't see how anyone could argue with that.

Mr. WHITE. As a matter of fact, really, our whole committee feels that way, that if we can't produce, we shouldn't stay in the program.

STAFF. Does the carrier group feel that medicare administration would be simplified and made more economical if physicians chose between either taking assignments for all of their medicare patients or direct billing for all of their patients, up or down?

Mr. WHITE. I am not sure I understand the question.

STAFF. For example, a physician said, "I will be a cooperating physician or participating physician," and he notifies Prudential of that.

In turn, Prudential is aware that he has agreed to take the medicare allowance for all medicare beneficiaries.

Would that be simpler administratively for you?

Mr. WHITE. Certainly, assigned cases are easier to handle purely because of the fact that they are prepared in the doctor's office and they fill out all the lines on the form, whereas, in the claims we get from beneficiaries, they leave out their number or omit things.

Administratively, assigned cases are easier to handle. There is no question about it.

STAFF. In your testimony, you strongly urged that each carrier be permitted to maintain and be provided with eligibility data on-site. Social security, we understand, the Bureau of Health Insurance, has raised some objections to that for several years now.

Would you indicate what their objections are?

Mr. WHITE. I am really not sure. We took this position back in 1965, right after the law was passed, that we should be permitted to operate as carriers.

In other words, to maintain policyholder record in our office.

In my case, all residents in New Jersey, in effect, would be policyholders of Prudential, and we would maintain their records. Wherever they went throughout the country, we would be responsible for their bids. They would be submitted to us. Frankly, I don't really know why this was opposed.

I think you would have to ask social security on that one.

STAFF. You were never given any reason?

Mr. WHITE. I can't remember. There was a lot of talk back and forth at that time.

As I have been trying to remember back in our debate on this particular subject, I think it would be difficult because these people move around.

On the other hand, we countered with, "Well, our policyholders move around, too."

I can't really tell you what the reasons are. I can tell you the reasons from our side why we wanted it but I can't tell you why it was rejected.

STAFF. The General Accounting Office, as you may know, has a report, a draft report, and it was referred to in a previous hearing, recommending that Travelers not be used as the carrier for railroad retirees, and that the railroad retirees be covered by local carriers, for ease of administration, reduction in cost, and to avoid having two levels of payment in an area.

For example, in New Jersey, on the railroad retirees, you would determine one level of customary and prevailing for those beneficiaries who are yours, and another level would be used for railroad retirees.

Has the carrier group taken any position on this?

Mr. WHITE. We have not taken a position, except I would like to respond in this way, that we in New Jersey, and speaking now for Prudential, all the Travelers, are perfectly willing to help them.

Our information is available to them. We will cooperate in every way we possibly could, and we have.

Mr. PATTERSON. We also have provided the profiles on the physicians' charges to the traveler, so there is not a dual standard.

STAFF. Is Travelers using your fee level for prevailing charges in New Jersey?

Mr. WHITE. I can't speak for what they are doing. All I can say is that we have offered to cooperate with them and provide them with information. I can't answer for them, obviously.

STAFF. They will be here tomorrow.

Mr. WHITE. Yes.

STAFF. Peer review is bandied about a great deal today as the answer to improper utilization of health services.

Based upon your knowledge and experience, how generally operative and effective is peer review in this country?

Mr. WHITE. Again, I have to be provincial. I can't really answer for the whole country.

In New Jersey, we have used county medical society committees. In fact, we had one situation of a doctor that actually quit practicing and moved out of the county because the peer review committee was so tough on him on the cases referred to them on overutilization.

This was an extreme case, but it did happen. We have had the cooperation of the medical societies on these situations.

Again, I can't answer how effective it is outside.

STAFF. Did they cooperate with you in examining the very large payments made to several physicians who ran a nursing home or two in New Jersey?

Mr. WHITE. They were osteopaths and, therefore, not members of the medical society.

STAFF. I think they were called osteopathic physicians.

Mr. WHITE. They were not members of the medical society so they couldn't use the existing method. Osteopath-physicians are not members of the State medical society.

We did, however, refer these particular physicians to the State osteopathic society. We had full cooperation from them, but they couldn't help us.

Mr. PATTERSON. May I add something? We have a good deal of activity with the utilization review committees by virtue of our extensive commitment in extended care facilities.

I think they might be categorized as from poor to fair, for effectiveness. Part of the reason, perhaps, for this, is that, again getting back to the extended care facility benefit and the problems in administration, you have actually four hands in the decision as to whether or not the care is offered.

First of all, you have the attending physician; the provider is expected to make a judgment. The utilization review committee of the provider, and then lastly, you have the intermediary who is in the position of having to overrule any or all three of these, which is obviously a very bad situation.

Some of the doctors, when they have been overruled or questioned, figure, "Well, why do we need utilization review committees? You are making the determinations."

While it is not the entire answer, certainly, I think the situation could be improved if there was some legislative relief provided for the extended care benefit.

STAFF. I believe that same point was made by administration witnesses a couple of months ago.

In that connection, and I know this is near and dear to your heart, and I am sorry that the Blue Shield people are not here, the staff, as you know from reading the report, stated strongly that utilization review is generally ineffective today and that it is extremely important for increased commitment and involvement of organized medicine at a local level, and possibly a State level.

In that context, do you people oppose the idea of paying physicians who spend 4 or 8 hours of their time serving on utilization review committees reviewing payments made by third-party programs?

Mr. WHITE. Are you talking about part A or B?

STAFF. Part B.

Mr. WHITE. I thought maybe you were talking about the committees in hospitals.

STAFF. If a medical society sets a regular group to review utilization of physician services and physicians agree to serve 4 hours a week, and meet weekly on that, should those physicians be paid on a professional basis for professional judgment?

Mr. WHITE. I have to respond personally. I am opposed to it. I will tell you why I believe this philosophically.

We in our own operation do employ physicians and pay them a fee. We have a panel of 40 consultants in addition to our own full-time medical people. It is to weed out these situations where we can handle them ourselves.

So we are not flooding the medical society with a lot of claims. We are only peering the cases where our own medical consultants we pay throw up their hands and say, "This demands medical society action."

At that point, it seems to me that the medical society ought to act independently. This is real peer review. They would not be in our employ which, in effect, they are if we pay them.

In one way, I can sympathize with their desire to be paid for their time.

STAFF. Might they not be independent contractors?

Mr. WHITE. We have used independent contractors all the way through this process, before it gets to them.

STAFF. Some of the medical groups have come in and argued rather strongly, and we believe honestly, for such payment not for any personal gain but simply as a professional function being professionally reimbursed.

Mr. PATTERSON. I think if the physicians wish to be compensated for this in some areas, this would be fine. I think there are other areas where they don't wish to be compensated. They feel it is part of their duty as a member of the medical community and would not want to be paid.

However, we have been approached with the question, "Will you share in any additional clerical expense?"

So far, we have just put that on the back burner and said we would be glad to consider it.

Mr. WHITE. I think there is something you have to look at here.

If in the development of the claim before the Review Committee they have to employ a clerk, perhaps we ought to reimburse that.

But I also think perhaps some of the medical societies that are complaining are in the situation—I don't know who is involved—where perhaps the carrier is dumping claims on a medical society, abdicating its own responsibility. I think that is wrong.

I think you ought to employ the physicians in your own organization to weed out the claims so that the number of claims you refer to the society will be rather a minimal number, so that you wouldn't have these fellows working long hours.

STAFF. Very simply, that sort of thing varies with the capacity of each carrier, I believe.

Mr. WHITE. Yes.

STAFF. Some have extensive review methods and others whirl around and point a finger in the air and say, "That one doesn't feel right."

That is not an exaggeration. That is what one carrier virtually told the staff it did, at least initially.

That concludes the staff questions for today.

By direction of the chairman, the subcommittee is in recess until tomorrow morning at 10 o'clock.

(Whereupon, at 4:45 p.m., the subcommittee recessed, to reconvene at 10 a.m., Wednesday, April 15, 1970.)

MEDICARE AND MEDICAID

WEDNESDAY, APRIL 15, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 2221, New Senate Office Building, Senator Russell B. Long, presiding.

Present: Senators Long, Ribicoff, Williams of Delaware, Miller, and Hansen.

Senator LONG. This hearing will come to order.

Yesterday, we heard from the carriers who serve as the Government's agents for part B of medicare—payment of doctors' bills.

Today, we will hear from the intermediaries who are the Government's agents for part A of medicare. In that capacity they deal with hospitals, extended care facilities, and home health agencies.

Part A of medicare is where officials have estimated a long-term deficit of $216 billion under present financing. We will be very interested to hear from the intermediaries concerning some of the causes of that deficit as well as the recommendations they might have for solving some of the serious medicare problems.

We will begin today by hearing from the representatives of the Blue Cross Association. We would appreciate it if you gentlemen speaking for the Blue Cross Association will take your seats.

I will have to leave, gentlemen, and Senator Williams will take the chair for that time.

STATEMENT OF BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT OF GOVERNMENT PROGRAMS, BLUE CROSS ASSOCIATION; ACCOMPANIED BY EUGENE SIBERY, EXECUTIVE VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. TRESNOWSKI. Mr. Chairman, my name is Bernard R. Tresnowski: I am senior vice president of Government programs for the Blue Cross Association, the national organization of Blue Cross plans. With me is Mr. Eugene Sibery, executive vice president of the association, who will assist in answering the committee's questions.

We appear here in behalf of those plans and the Blue Cross system and reflect their awareness of the responsibilities and duties that Blue Cross assumes as the major organization for prepayment of health care benefits in the United States.

This role includes providing health care benefits to more than 70 million people under private contracts, 5 million of whom are in the Federal employees benefits program; serving as the major fiscal in-

termediary in medicare; participating actively in the administration of medicaid in 22 States; and administering benefits in 33 States under the civilian health and medical program of uniformed services. Additionally, Blue Cross has begun participation in the model cities and neighborhood health center programs.

We are here to discuss two Government programs that have much in common with Blue Cross goals; namely, titles XVIII and XIX, known as medicare and medicaid. We are here in response to your invitation and because the Blue Cross system has a vital interest in the health care of the Nation.

As part of our commitment to serving the health care needs of the American people, Blue Cross undertook a major role in the medicare program when it began in July 1966. As intermediary for institutional benefits under part A, the Blue Cross system has served the vast majority of persons participating in the program by providing administrative services to the Social Security Administration and to 93 percent of the hospitals, 87 percent of the home health care agencies, and 53 percent of the extended care facilities participating in medicare.

When the medicaid program started on January 1, 1967, Blue Cross plans in many States assumed administrative roles in this program. In addition, the energies and talents of the Blue Cross system were utilized in preparing for, initiating, and then administering these new, significant programs.

The magnitude of the job is seen in the fact that in less than 4 years the amount of medicare claims handled by the Blue Cross system has grown from zero to a rate of approximately $4.5 billion a year.

As the impact of these two major governmental programs has grown, so has the expertise of the Blue Cross system in performing its duties under these programs. We have seen the need for improvement in them and have helped to implement several changes which have improved the quality of service provided to the persons taking part.

However, some further improvements are required, basically in the areas of (1) greater simplification of benefits and methods and (2) building greater incentive for provider productivity. Our legislative recommendations for meeting these needs will be outlined later in my testimony.

While these part 4 years above been years of challenge, opportunity, and greatly increased service for the Blue Cross system, they also have been a time of testing and proving for the structure and operating system of the medicare and medicaid programs.

Our experience as a participant in the medicare program has shown that the role of intermediary is a meaningful one, a role which contributes to the success of medicare in several ways.

In reviewing this performance, it should be noted that the overall performance of the Blue Cross system in administering medicare has shown steady and impressive improvement since the program went into effect.

The following indexes of performance are significant, showing both improvement in the service provided and a steadily improving range of performance by the system.

BLUE CROSS PERFORMANCE TRENDS

[Fiscal year]

	1967	1968	1969
Claim processing:			
Weeks work on hand:			
Average of all Blue Cross plans	1.7	1.4	1.1
High plan	10.0	8.2	3.0
Low plan	0.1	0.1	0.0
Over 30 days pending (percent):			
Average of all Blue Cross plans	15.6	16.0	12.5
High plan	39.7	53.5	33.2
Low plan	0.0	1.6	0.0
Inpatient processing time (days):			
Average of all Blue Cross plans	8.7	7.5	7.6
High plan	41.0	27.3	30.3
Low plan	3.8	2.2	1.6
Administrative costs per productivity:			
Administrative costs per bill (excludes provider audit):			
Average of all Blue Cross plans	3.30	2.77	3.24
High plan	7.82	5.92	5.25
Low plan	1.54	1.53	1.77
Claim productivity per employee per year:			
Average of all Blue Cross plans	2,497	3,127	2,990
High plan	4,641	5,128	5,029
Low plan	1,057	1,678	1,726

Mr. TRESNOWSKI. Blue Cross is one of 11 intermediaries operating under contract for part A of medicare. Of the other 10, three well-known commercial carriers operate under a prime contract with administrative functions carried out in various geographical locations around the Nation, as does the Blue Cross Association through its member plans. A review of the comparative data between Blue Cross and these three intermediaries shows a broad range of performance.

JULY–SEPTEMBER 1969 [1]

	Administrative expenses per bill	Bills processed	Ratio of administrative expenses to benefit payments (percent)
Blue Cross:			
All Blue Cross plans	$3.67	3,509,861	1.22
High plan	5.68	3,373	1.95
Low plan	1.90	18,394	0.63
Company A (14 offices)	5.73	97,598	1.59
High office	9.90	416	4.52
Low office	4.76	1,183	1.04
Company B (23 offices)	5.32	69,428	2.05
High office	6.08	1,715	3.16
Low office	4.22	23	1.61
Company C (9 offices)	5.13	76,647	1.31
High office	7.64	12,093	2.75
Low office	3.63	1,884	0.87

[1] Source: SSA Memorandum to All Part A Intermediaries on Selected Workload and Cost Data Dec. 23, 1969.

Mr. TRESNOWSKI. The role of the Blue Cross Association, in coordinating and administering the work of the Nation's Blue Cross plans under medicare, is now new to BCA. For many years BCA has served the plans, coordinating resources, providing national u[illegible]mity for a system with decentralized administration, insuring discipline through conditions of membership, coordinating leadership, and centralized technical skills, thereby avoiding widespread duplication.

Examples of the centralization of skills include the operation of a vast telecommunications network and data processing center, work in EDP programing and implementation of the programs, development

and provision of training and education programs, recruitment of key personnel, and representation and liaison with a myriad of national organizations. Also, BCA has developed review mechanisms and model systems for the maintenance and continuing improvement of Blue Cross plan performance.

The capabilities and experience of BCA proved to be of considerable value when the Blue Cross system undertook its duties in the medicare program. Especially important to the success of the program has been the Blue Cross Association's ability to provide:

One accountability point for the entire system, enabling fast implementation of policy;

A national telecommunications system, obviating the need for HEW to duplicate it;

Coordination of fiscal policy and implementation of negotiated cost settlements;

Evaluation of plan performance and technical assistance to the plans;

Assistance to the Social Security Administration in formulating and interpreting medicare regulations and instructions;

A sharing with SSA of the responsibility and accountability for implementing program policy;

Effective rapport with major hospital and other health associations, furthering understanding of and conformity with the program and any changes in its administration and operation;

The ability to coordinate work among various Government programs with which Blue Cross is involved, such as CHAMPUS, the Federal employees program, and model cities.

Being able to provide these services and abilities to SSA in the administration of medicare has enabled Blue Cross to contribute significant savings as well as effective, efficient service to the medicare program. The desirability of having a point of accountability with implementation and problem-solving close to the local problems involved has been made clear in the first 4 years of the program.

To give further specificity to the accomplishments of the Blue Cross Association in its duties under medicare, we should review some of BCA's activities in fulfilling its responsibilities to the Nation's 20 million medicare beneficiaries. These include:

Development of a tape-to-tape system to speed claims processing and eliminate clerical errors in handling the claims. This system, of sending claims to SSA's Baltimore center on magnetic tape for processing in SSA's computers, has not only speeded payments to medicare beneficiaries but also has resulted in dramatic cost reductions. It is estimated that savings through the tape-to-tape system for the current fiscal year will be more than $1,250,000. Another benefit of this system is that the information gathered through its use can be used to help increase knowledge and effectiveness in the areas of claim processing, use of health care facilities, management statistics and health institution reimbursement. Presently 33 Blue Cross plans participate in tape-to-tape claims transmission, and BCA is working to have all plans in the program by the end of this year.

Development of an automated "model system" for handling all elements of part A intermediary work. The tape-to-tape program will be one part of this system. This "model" system will integrate the various medicare administrative functions into a uniform, com-

puter-based part O medicare operating process. Compatible with SSA's operations, the system will further speed claim processing and billing. Three model subsystems will be installed in a pilot Blue Cross plan on the following schedule: outpatient claims May 1, inpatient and ECF claims July 1, and home health claims September 1.

Development of reimbursement simplification and audit programs for multiple hospital corporations, such as Catholic hospitals.

Implementation of guidelines on the level of care provided under medicare, developed by SSA in consultation with BCA, guaranteeing that this policy would be adhered to with reasonable uniformity.

Development of a wide range of reimbursement policy and interpretation directives for providers taking part in the program. A total of 215 standard practice administrative bulletins have been issued, giving direction on, for example, auditing of teaching hospitals, procedures for limited-scope auditing, computation of Sisters' maintenance among many others.

Provision of quality control on cost reports and audit firms which include a checklist review of each completed cost report submitted by the audit firms and Blue Cross plans. This activity has provided data to develop profiles of performance of audit firms which has been helpful in negotiating audit subcontracts.

Resolution of claim production problems through the BCA-Baltimore office. Significant savings have been achieved by having rejected claims reviewed and corrected on site at SSA without the need for resubmission to each Blue Cross plan.

Compilation of performance data which are provided to SSA and the plans on a consistent and timely basis.

Provision of on-site technical assistance to plans in areas, including management, EDP, claims processing, and utilization review.

Development of a single cost allocation system within plans to assure consistency in financial management.

Development of standard administrative procedures for extended care facilities which are part of a regional or national chain.

These are some of the accomplishments of the Blue Cross Association, working as part of the Blue Cross system, in fulfilling its duties as administrative intermediary for medicare. The list is not complete; there are many other items which could be added. But, just as important as the accomplishments—and as the work now in progress to further improve the job Blue Cross is doing in medicare—is the continuing commitment and dedication of the Blue Cross system to seeking the highest standard of performance and excellence in its work for Americans 65 and older.

During the annual meeting of Blue Cross plans held earlier this month, the BCA board of governors strengthened its commitment to high standards of performance. The board unanimously approved a resolution authorizing BCA to replace a plan or revise significantly its subcontract in instances where plan performance is not satisfactory, as necessary to achieve high peformance.

Though there has been considerable improvement in the program, overtime it has become evident that legislative changes will be necessary before some needed improvements can be made.

To increase the effectiveness of medicare and medicaid, Blue Cross wishes to make the following legislative recommendations:

Provider reimbursement: The provider reimbursement methods developed under title XVIII and applied to title XIX have stimulated the development of functional cost determination which has been helpful to provider management as well as all who purchase care.

Through law and regulation these programs have described and defined the elements of provider costs allowable under the programs. Though there will continue to be debate over the allowability of or limitations on certain elements of cost, the need for limits is unquestioned.

The major problems with titles XVIII and XIX payment arise out of two factors; that is, (1) the method of allocating costs to the programs (ratio of charges to charges applied to cost) and (2) the absence of effective incentives to limit increases in cost.

Payment on the basis of RCCAC has required the accumulation, reporting, auditing, and verification of extensive cost and charge data and detailed statistics, which placed a heavy and costly administrative burden on providers; created a sizable administrative cost for auditing and verification; and significantly delayed the conclusion of retroactive cost settlements.

To assist providers with the difficulties in this method of payment and to accommodate various provider accounting capabilities, several options were made available. Options include: RCC Departmental; RCC Combination with Cost Finding: RCC Combination with Estimated Percentage; Option for All-Inclusive Rate Providers.

The effect of these options has been to permit payment of significantly different costs for any given provider, dependent on the option chosen. For example, one hospital in New York through election received $500,000 more in a given year from one option than from an alternate.

Experience under medicare, medicaid, and various Blue Cross provider payment methods has demonstrated the need to assure that the payment method provide: (a) simplification of administration, (b) predictability of payment (to the payer and the provider), (c) incentives for efficiency.

Whatever the methods selected, the provider must be put at risk under carefully defined and prenegotiated circumstances. The cost-plus or charge reimbursement formulas that we have been using since World War II cannot be justified in an essentially noncompetitive economy.

Recommendation: We recommend that, in the interests of simplification, the method of allocating provider costs top rogram beneficiaries be revised to a per diem cost basis with appropriate adjustments related to factors specific to the aged population. The program should eliminate RCCAC, its options, and its need to accumulate and audit massive data.

We also support the expansion of the scope of experiments and demonstration projects to develop incentives through methods of financing for economy in the provision of health services.

Maximum use possible should be made of the variations in method that now exist and that can be expanded or elaborated in given localities with good prospects of significant local participation.

We recommend that planning of health facilities be supported by these two programs by directing the Secretary to consider the actions of comprehensive health planning agencies, areawide planning agencies, and regional medical programs in the development of payment methods taking into consideration provided participating status, under planning.

In support of this approach, recognition should be given to any transition phase where planning is in a developmental status, where there is an absence of appropriate planning data and technical skills.

UTILIZATION REVIEW—BENEFIT ADMINISTRATION

Blue Cross has had extensive experience with and knowledge of relationships between benefit determination through claim administration and the role of utilization review established as a peer review device of institutional medical staffs.

The administration of diagnostic exclusions from private Blue Cross contracts some years ago served as the stimulus to develop utilization review committees as support for decision concerning the purchase of service by third parties. This experience has revealed that extensive periods of time are needed to educate physicians as to the limits and meaning of benefit exclusions and to assure their full participation and cooperation in the claim process.

Under medicare and medicaid, it is contemplated that health institutions will have peer review committees of medical staffs concerned, on an ongoing basis, with effective use of health services and benefit exclusions based on law and regulation.

If, however, either program contemplates not paying for care judged ineffective on a case basis, the patient might be used as a pawn, for example, asked to pay the bill. Also, many provides, for example, consider it unrealistic for them to be left holding the risk where patients can't or won't pay.

The challenge is to design utilization review as a continuing administrative influence, as a means of broadening medical decisions to take into account quantitative as well as qualitative matters and as a working partner with benefit or claims administration.

Under present law, utilization review committees are expected to upgrade quality of care and also monitor length of stay, use of services, and the need for admission; all of the latter three potentially involve a lesser payment by medicare; for example, confined to what is appropriate. Institutional utilization review committees have developed utilization review plans to meet the form prescribed by the statute, but have not, in many cases, developed substantive actions of control in part because of their reluctance to mix professional and economic functions.

Our review of the certification, recertification, and extended stay review activities have revealed widely varying performance because of lack of understanding, variable commitment to utilization review as a peer review mechanism, and rebellion against Government-generated criteria for medical necessity, among others. On the other hand, our role as intermediary in claims review affecting use of services, has been greatly augmented and developed.

Considerably time and effort has been and will continue to be necessary to achieve understanding among beneficiaries and the medical

community of the limitations established by legislation and regulations and of relative roles.

A great deal of the problem develops out of what has evolved as an apparent conflict between the provisions of section 1861(k) of the act concerning the role and function of utilization reviews, and section 1862 of the act, which describes the exclusions from coverage under the program, and section 1814, which identifies condition of and limitations on payment of service.

RECOMMENDATION

We recommend that section 1862 of the act be amended to identify benefit exclusions specifically through the use of criteria promulgated by the Secretary through regulation and implemented largely through the intermediary.

We recommend that section 1814 of the act be amended to provide that physicians' certification serve as presumptive evidence of covered care subject to review by the Secretary through the intermediary.

MEDICAID

The enactment of title XIX of the Social Security Act in 1965 announced as public policy that health care should be accessible as a matter of right to all persons medically and economically disadvantaged. The program also established as an objective a pattern of comprehensive benefits.

Experience with this program has shown problems principally in the definition and identification of eligible persons, predictability of cost, and the need for administrative simplicity and greater impact on the delivery system by controlling cost and use at the local level.

RECOMMENDATION

We recommend that eligibility be established based on a fixed income limitation per family determined by a simple declaration of income to be effectve for a period of 6 months to a year. We recommend that a uniform Federal contribution rate be established that would be met by the States on a sliding scale.

We recommend that the Federal Government exercise a stronger role by the establishment of program objectives, performance standards, and evaluation of results and administer the program through Federal Government-approved carriers, two or more, within each State. Participants in the programs would be allowed to choose among the carriers, which, because of their different forms and the necessity of operating within a rate, would be innovating, attempting to change the system and reflect local conditions.

The following specific comments and recommendations are offered to either clarify administrative authority, simplify benefit design, streamline administrative procedures, or underscore congressional intent:

HOSPITAL-BASED PHYSICIAN

In our testimony before this committee on August 31, 1967, we urged combined billing for hospital-based physician services which would improve beneficiary understanding of the program and sim-

plify the administrative burden and cost of artificially separating billings between parts A and B for these services. The 1967 amendments to the Social Security Act provided the option for combined billing for radiologists and pathologists. However, other hospital-based physicians—for example, cardiologists, neurologists, psychiatrists, and attending physicians characterized as "supervising physician in a teaching setting"—are still required to submit separate billings.

In addition to the administrative problems this has created, it has been exceedingly difficult to precisely identify the amounts to be charged to the respective trust funds, especially in large teaching hospitals.

RECOMMENDATION

We recommend that the provision for combined billing now available for pathologists and radiologists be extended to all hospital-based physicians, including attending physicians in teaching setting where arrangements exist between the physician and the hospital. In accord with the provision governing radiologists and pathologists, we recommend elimination of the $50 deductible and co-insurance provisions for all hospital-based physicians.

INSTITUTIONAL BENEFITS UNDER PART B

Institutional out-patient benefits are included under part B of the program, subject to the $50 deductible and co-insurance. Also, ancillary services provided by hospitals are covered, subject to this deductible and co-insurance.

In addition to the home health benefit available under part A of the program, there is an additional 100 days available under part B with a different criterion for admission with a deductible and co-insurance factor. All of these part B benefits, although functioning under differing program requirements, are administered by the part A intermediary and are all reimbursed on a reasonable-cost basis.

There are fundamental administrative problems in providing what are essentially part A benefits financed out of the part B trust fund. These include, for example, the need to establish separate eligibility queries and different benefit criteria under home health services.

RECOMMENDATION

We recommend that all hospital out-patient services be part A benefits subject to a straight 50 percent co-payment by the beneficiary, with the maximum payment of $20 for any series of related billings by the same hospital and a minimum billable medicare benefit of $2.

We recommend that all part B health services billed for by the hospital, including ancillary services, be covered under part A with the elimination of the $50 deductible substituted with an appropriate co-payment.

We recommend that home health services provided under part B be transferred and appended to home health part A benefits, subject to the same requirements of eligibility.

OUTPATIENT PHYSICAL THERAPY

A new benefit for outpatient physical therapy was included among the 1967 amendments. The language of the amendment to the law established coverage for such services when furnished to a beneficiary ". . . as an outpatient." Because of that particular phrasing to the amendment, the program will not permit a provider qualified to furnish physical therapy to furnish such service to its own inpatients but will permit that provider to obtain physical therapy services for its own inpatients from another medicare provider.

This results in two providers, both qualified under the program to provide physical therapy, having to make an arrangement with each other to exchange physical therapy services in order to qualify the beneficiary for payment of the service.

RECOMMENDATION

We recommend that the language of the law and the intent of Congress be clarified to avoid such illogical and unnecessary arrangements between providers.

DURABLE MEDICAL EQUIPMENT

Currently, durable medical equipment may either be rented or purchased under the program. However, the decision to rent or to purchase may only be made by the beneficiary. This results in instances where the beneficiary elects to rent an item of durable medical equipment for a year in spite of the fact that if the rental allowances were paid toward purchase of the equipment the item would be entirely paid for in 6 months. Therefore, the program pays in rental charges twice what would be necessary if the equipment would have been purchased.

RECOMMENDATION

We recommend that the program requirements be changed to permit intermediaries to determine, based upon evaluation of the period of time the equipment will be necessary, whether that equipment will be purchased or rented and to make acceptable financial arrangements where the beneficiary is unable to advance funds to purchase medically necessary durable equipment.

These recommendations will improve the effectiveness of the medicare and medicaid programs, opening up important, new opportunity for better administration and operation. But, more importantly, implementation of our recommendations will help assure that all the goals of the programs, in providing needed health care services to large numbers of Americans who had been outside the mainstream of health care, will be fulfilled.

Senator RIBICOFF (presiding). Thank you very much. Senator Williams.

Senator WILLIAMS. Did you consider whether your proposed method for reimbursement of hospitals would result in higher or lower costs than under the present formula?

Mr. TRESNOWSKI. The proposal which is included in the testimony is very close to an arrangement that is being negotiated at the present

time between the Social Security Administration and American Hospital Association concerning adjustment for a nursing factor in the reimbursement system. We think this is an acceptable arrangement. We think it will greatly simplify the administration of the program.

Senator WILLIAMS. Which local Blue Cross plans are not rendering a satisfactory level of medicare performance at the present time in your opinion, and what plans do you have to get inefficient members out of medicare?

Mr. TRESNOWSKI. We have a wide range of performance activities we conduct through the Blue Cross Association, and this includes, first of all, the accumulation of data on performance. We sift this data and arrange it in such a fashion we can highlight the performance of the various Blue Cross plans.

In our testimony, we show the varying range of performance within the Blue Cross system and among intermediaries. We were struck by the range of performance, as the committee was and the staff was. We pursued that avenue and found there are as many as 95 different variables that could influence performance, the principal ones being the number and character of providers that we are servicing, their geographical distribution among others. The approach to the problem has been to establish peer groups of Blue Cross plans and to rank their performance within peer groups.

When we place them in a peer group, we are then better able to identify whether their performance is significantly out of line with a Blue Cross plan of the same size and same type of providers and so on.

Senator WILLIAMS. Your insurance is primarily conducted with those below the age of 65, is that right?

Mr. TRESNOWSKI. We also write complementary coverage for 9 million aged to the medicare program.

Senator WILLIAMS. That is supplemental insurance?

Mr. TRESNOWSKI. Yes.

Senator WILLIAMS. Medicare?

Mr. TRESNOWSKI. Yes.

Senator WILLIAMS. How do you work where you have an elderly person who is not under medicare? Do you continue to insure them, or do you drop them entirely or do you just offer supplemental insurance? How do you work it?

Mr. TRESNOWSKI. It depends on whether the aged are part of the group, whether he is a retiree of the group or an individual. A lot depends on circumstances surrounding the option to select or not select a medicare coverage. There are some aged that do not qualify, and there will be more of those, and we plan to provide coverage for them.

Senator WILLIAMS. You plan to continue coverage, if they wish to carry it, without medicare?

Mr. TRESNOWSKI. That is correct.

Senator WILLIAMS. You will not force them to move into medicare in addition if they object?

Mr. TRESNOWSKI. Let me clarify. It depends upon the reason for their election not to come under the medicare program.

Senator WILLIAMS. In your reimbursement recommendations on page 12, you recommend payment of per diem costs adjusted for factors with regard to the aged population. What are those aged specific factors and what kind of adjustments are you suggesting?

Mr. Tresnowski. The factors are principally a nursing factor. There have been a number of studies conducted which have demonstrated that the aged require more nursing services, and it was based upon these studies that there was a general consensus there ought to be a factor adjustment. This will be somewhere between 95 to 100 percent of average per diem.

Senator Ribicoff. I am curious: on your supplemental and complementary policy what do you find the average size of the claim is that you pay?

Mr. Tresnowski. It depends upon the coverage, upon the particular claim, Senator Ribicoff. The complementary coverages are largely written to fill the gap such as deductible and coinsurance: but if benefits expire, for example, if they run out of the spell of illness, there is provision to pick that up: so it would vary.

Senator Ribicoff. Is it sizable?

Mr. Tresnowski. No, it is not.

Senator Ribicoff. In other words, the medicare payments will generally pay the full costs of an illness? Do you find there is a large gap?

Mr. Tresnowski. The claim is substantially paid by medicare.

Senator Ribicoff. Substantially pay the amount?

Mrr. Tresnowski. Yes.

Senator Ribicoff. Now, yesterday the representative from the Pennsylvania Blue Shield suggested the possibility of pilot programs or experimental programs that they thought should be devised as a substitute for the methods now being used in medicare. Have you given thought to this yourself?

Mr. Tresnowski. I would like to respond with a reference to a suggestion we made as far as title XIX. We do recommend, in the testimony, that title XIX be restructured along these lines and that the States be authorized to enter into underwriting arrangements with two or more carriers competing within a State. We have developed this and are continuing to develop it for title IX. I would like Mr. Sibery to respond.

Mr. Sibery. Mr. Ribicoff, with respect to medicare, we do believe that it is feasible to continue to study this possibility. Many assumptions are made in trying to give you the information with respect to medicaid. Assumptions would also have to be made with respect to the coverage or eligibility and the risks undertaken with respect to title XVIII, or medicare.

We believe it is worthy of study, very worthy, and we feel that the general principles we have laid out with respect to medicaid with appropriate modification could serve as a basis for further study in relation to medicare.

Senator Ribicoff. Would there be interest on your part, or the entire association, to give the committee some alternate suggestions as to what might be used? What I have in mind is giving HEW some authorization to try three of four pilot programs around the country to see how they work. I would not want to substitute any broad-gage plan that is different, but I think with anything that is so widespread and so costly, involving so many people, we ought to experiment a little.

I think when you consider the size of the country, the number of communities involved, it would not be too difficult to have three or

four pilot programs on different methods to see how they would work. I would be interested in that.

But I would invite, from those of you who are involved and are experienced to come up with suggestions for committee study. If there is interest on your part, I would hope you would submit it to the committee so we can take it up with HEW and probably have some authorization in the legislation for some pilot programs.

Mr. Sibery. Senator, we certainly will be willing to give this further study and attempt to submit something which will be helpful. We do believe that any experimentation, however, would have to have the objective of the program pretty well outlined, and we feel that in this regard, our assumptions might well then later become either the objectives for the program or the standards by which performance would be judged, but with the understanding we would have to make assumptions in order to present something, we will further develop it and certainly study its feasibility.*

Senator Ribicoff. You are interested, of course, as intermediary in medicare. At the same time you have your own assured under 65 and take care of their policies, whether they are individuals or a group. How do you operate on a utilization basis in both programs—your own and where you are intermediaries?

Mr. Sibery. Mr. Tresnowski will speak with respect to the intermediary, and I will then speak with respect to our own underwritten business.

Mr. Tresnowski. Blue Cross has had long experience prior to the program in utilization review. Many years ago we wrote contracts with diagnostic exclusions, perhaps you remember them. In order to administer the diagnostic exclusions, we had to encourage the development of peer review devices in the institution, which, of course, were forerunners of the development of utilization review committees.

What we did is, use the utilization review to help us to identify on a claim basis whether a claim was diagnostic or not. We had a long and difficult experience with that; we went through 4 or 5 years of trying to get the medical profession to face up to what was essentially an economic decision rather than medical, although it had medical overtones.

We moved from that responsibility and that experience into the medicare program, which gave them major responsibility. We found, as we indicated in the testimony, some fundamental conflicts in the statutory mandate and our ability to administer claims, and we made certain recommendations on how we think it should be corrected.

We happen to feel now that the major payoff in utilization review is through the claims review mechanism, using the review committee as support with the decision to be made through the claims review mechanism because this is ultimately the point where you control the dollars.

Senator Ribicoff. Are the utilization committees in the hospitals working?

Mr. Sibery. I suggest, in our testimony, that we have indicated that certainly the form is there, and having had personal experience recently in hospital administration, I can assure you it is difficult to measure the payoff. If you can enlighten a physician through peer

*See letter, p. 312.

review and the educational process whereby his behavior is significantly changed, then his payoff to us and to society as a whole is great over a period of time.

We feel, however, that there are some definite barriers that are retarding our efforts, and this is why Mr. Tresnowski is speaking both with respect to those activities for which we are a carrier, or intermediary, and those for which we are an underwriter, and we feel we have to do more through the claims review process.

We do not believe, Senator, that it is a matter of abandoning the peer review but rather utilizing it then for specific evaluation and judgment when certain things through other criteria are highlighted and brought to their attention.

Senator RIBICOFF. Well, have you sat down with any individual hospital and their medical staff and said:

> Look, this is not working; you have to take responsibility. Here you are, servicing and taking care of so many patients, and the amount of money paid to you is *x* dollars, and you have an obligation with us and the country and the taxpayers and the aged to make this work.

Now, why is it impossible, in cooperation with the medical societies, hospital medical staffs, and the hospital administration, to get a utilization committee that works? Again, it was the intention of the Finance Committee not to have the long arm of bureaucracy come in and dictate to the doctors and hospitals how to work. We relied on the good faith of the hispitals and the doctors that they would police themselves.

I don't think there is desire on the part of us to police the medical profession or the hospitals, but what do you have to do to get them sincerely to police themselves?

You have a responsibility which I don't believe you intermediaries have discharged. The intermediaries were put in as a buffer against bureaucracy. We assumed you had experience in your health plans, working with hospitals and doctors, and you were much more acceptable to them than a bureaucracy, and we now find a breakdown and we wonder if bureaucracy wouldn't work better.

Mr. SIBERY. I have to say to a substantial degree it has worked but not to the level of our expectations and certainly not to your expectations. I think that in the enumeration of important influences, you mentioned the intermediaries, you mentioned medical staff and administration, but you eliminated probably——

Senator RIBICOFF. And society.

Mr. SIBERY. Yes; you mentioned society, but within the institutional setting, you removed one of the most important ingredients, and that is the hospital board of trustees. I think this is one place where we have not yet been able to create a flame of enthusiasm for really making certain that various things do function at optimum levels within the institution, and I would just suggest that this is perhaps where I see the greatest payoff in the future. Our responsibility, increasingly, with respect to our own underwritten business, is to make the hospital more publicly accountable, and we feel this is basically the responsibility of the hospital governing board.

Senator WILLIAMS. In line with that suggestion, I am not quite sure I understand what you mean by the problem with the trustees. Certain hospitals are jealous of the reimbursement being allowed another hospital and try to adjust their rate upward? What is the problem?

Mr. Sibery. In this regard, Senator Williams, I was not suggesting jealousy with respect to rates or anything else, but I was suggesting, for the reasons outlined in the testimony, there have been some definite barriers which have precluded utilization review as the only mechanism functioning at a level we think is acceptable.

There certainly are problems with respect to competition between hospitals for "stays" within communities, and this is why we strongly support areawide planning. There are problems certainly with respect to being responsive to a community. We feel that our community responsibility will be complemented if the hospital governing board recognizes its community responsibility to a greater degree.

I was attempting to add one more ingredient which I think the committee must recognize: that the hospital governing board has a major responsibility even with respect to seeing that utilization review effectively takes place within its institution.

Senator Ribicoff. That is not going to solve the problem on a day-to-day basis, for this reason. The average board of trustees at the hospitals are public spirited citizens of the community who may attend a meeting only once a month. They are all busily engaged in their own activities and they may spend a late afternoon or evening at the hospital. But what we are dealing with now are thousands and thousands of people coming in week in and week out on a day-to-day basis, and we have the doctors and administrators in the hospital every day, and you have jealousy on the part of medical staff not to have interference from the Lay Board. This is always a schism in every hospital I have known, and I have not known a hospital to be able to solve that schism.

So you still are going to have to rely upon the medical staff and administrative staff of the hospital, of course, and whatever is agreed upon can and should be backed up by the Lay Board. The medical profession is under stress and under criticism, much of it deserved. I believe they have reached the stage where they are unhappy with the criticism and poor image they have in the country. They are aware, medical societies and doctors, of what has happened to their image in the overall community.

The intermediaries have an obligation. This is not the long arm of bureaucracy. You are dealing with them. You deal with them on all levels, not only on medicare, but you are dealing with the same people under your other health insurance plans, so they know you. In many instances on your Blues or your board of directors there are probably doctors, maybe it is a majority in many of them. There is no reason why you shouldn't take the responsibility of bringing together the medical society, the hospital directors, administrators, and the medical staffs, representatives of the medical staff, to make sure that utilization works. There is no reason why you can't do it.

What we are trying to say to you in the medical profession, "We don't want to inject bureaucracy; we want you to run your own operation, but to run it correctly."

Why can't you people get in on the corrective procedure?

Mr. Sibery. I believe I understand the point you are making, and I was only trying to illustrate the hospital governing board is a significant factor which cannot be overlooked.

We are not suggesting in our testimony that has been presented before you a substitution entirely of the claims review process with respect to utilization review committee. We are saying to you with respect both to that and to our own underwritten activity, the utilization review committee alone is not enough. We are suggesting that there be criteria whereby standards can be established, and through the claims review process we can litigate cases which then we can use with the utilization review committee.

We think this is a shift in emphasis and approach, but we feel that it is a shift that is necessary in order achieve the objectives for it.

Senator RIBICOFF. Aren't you doing claim review now?

Mr. SIBERY. Senator, we are doing claim review. We are doing claim review on the basis of data available.

With respect to the medical information, with respect to many of the procedures, there is insufficient data at this point in time to do the kind of utilization review that we are talking about through the claims review process.

On our own underwritten business, we are experimenting now with approaches whereby we can have access to more data, in order to make better judgments as to what cases need to be reviewed in greater depth.

This, we intend to intensify. We are suggesting, if this is permitted, if this criteria could be established by the Secretary through regulations promulgated by him and his Department, that this would be a significant shift for medicare and would be highly beneficial.

Senator RIBICOFF. Would you send to the committee your recommendations as to what regulations the Secretary should promulgate to make sure you can have this review? And, of course the committee, in its rewriting of the medicare law, can make sure that such rules and conditions and regulations are put into effect.

We would like you to send the committee your recommendations as to what you need from the Secretary or from the law to enable you to undertake such a review.

Mr. SIBERY. We shall be pleased to do so.*

Senator RIBICOFF. Now what are the specific functions of your association under medicare in relation to the functions of local Blue Cross plans who serve as intermediaries? How do you coordinate the activities? You are the parent, and how do you take care of your children?

Mr. TRESNOWSKI. We identified in some detail in the testimony the role of the Blue Cross Association in supervising performance of subcontracting Blue Cross plans. We provide a whole host of substantive technical assistance and also accumulate performance data and conduct extensive onsite review of activities of Blue Cross plans, and maintain a close surveillance on them.

We also review every provider cost report and final settlement that is made before it is transmitted to the Social Security Administration. We prepare various directives and policy statements concerning the operation of the program as related to the Blue Cross system. We operate a very extensive responsibility in the supervision of the plans.

Senator RIBICOFF. What do you do if you come across local Blue Cross violations?

*See letter, p. 312.

Mr. TRESNOWSKI. We send a lot of people to the Blue Cross plan and start at the top and work our way through. We find out if there is a complete and total management commitment to delivery of the subcontract. We go into systems analysis and examine reimbursement functions and provider relations and, first of all, find out why they are performing badly, and then take corrective action.

We have done it in a number of instances.

Senator RIBICOFF. It has been suggested—Senator Williams suggested, and I agree with him—about the possibility of having an inspector general function in the medicare program in HEW for independent check on what is going on in the whole medicare program.

How do you react?

Mr. TRESNOWSKI. We in Blue Cross have been in favor of public accountability. As you know, in the regulation governing our private business and those involving our government contracts, we are examined and reexamined constantly. We welcome it, frankly. We are that kind of an institution. We want our performance evaluated and highlighted. We feel that through this type of evaluation, we can do a better job.

We would have no difficulty with that whatever.

Senator RIBICOFF. Would you relate to us two things? One, what is there in the law that prevents you from doing a better job? Second, what is there in HEW regulations that prevents you from doing a better job?

Mr. TRESNOWSKI. I think the first recommendation that we made concerning provider payment is probably the most important one we would make before the committee. There has been criticism of the delay in the receipt of cost reports from providers, completion of audits, conclusion of final settlements. There are a whole host of reasons surrounding that activity. We feel the principal reason is the type of reimbursement system developed under the program, the need for detailed statistics, accumulation and auditing of statistics, application of the RCCAC concept.

This places a burden on hospitals unknown to them before the program started, and in many ways unrealistically. It places a burden on intermediaries we didn't anticipate, and places a serious policy burden on the administration in trying to carry it out.

We think the reimbursement system needs simplification and predictability on behalf of yourself and the provider. We think this would be a most important change that could be made.

The second one we identified and you discussed a minute ago with Mr. Sibery, which has to do with utilization review. We make specific recommendations concerning change in language of section 1862 of the act concerning "exclusion" administration. We point out there appears to be fundamental conflict between our ability to administer exclusions under the law and the mandate given to utilization review committees under section 1861(k) and others.

Senator RIBICOFF. Anything else?

Mr. TRESNOWSKI. We made other recommendations concerning hospital-based physicians, which is a nagging problem both in terms of administration and for other reasons, to the beneficiary, say, in terms of confusion. We recommend that all hospital-based physicians be

given the option of combined billing granted as in the 1967 amendments to the Social Security Act. We urge that provision for supervising physicians in the teaching setting which would eliminate a serious problem identified in the last couple of years.

Senator RIBICOFF. How would you react to, I believe the chairman's suggestion, on the reasonable basis of having a set fee schedule?

Mr. TRESNOWSKI. For physicians?

Senator RIBICOFF. Yes.

Mr. TRESNOWSKI. We don't administer the part B program or the physicians' salary. Mr. Sibery can speak to it.

Mr. SIBERY. We are really not in a position.

Senator RIBICOFF. It is a staff position, but I will assume it for myself.

Mr. SIBERY. We do not administer service benefit programs, physician service benefit programs rather. We would say to you, or I would say to you certainly we believe that any type of payment program certainly must be related to the productivity, whether it is on the institutional or professional side. It certainly has to relate to public accountability.

This will require some kind of standards. With respect to the specific approach, whether it be a fixed fee schedule or something else, I think that it has to be able to meet the test of certain objectives for the payment mechanism that should be well established and clearly enunciated, and public accountability and efficiency in productivity which would tie in incentives are very important.

Senator RIBICOFF. After all you are an important part of the entire health apparatus, from beginning to end. And you are certainly aware of what goes on in the entire health field and the burgeoning cost. And how do you react, or how did you react, or how do you still react to the great differential in fees being paid to doctors under the Blue Shield arrangement and under medicare for the same procedures, same operations, the same services?

Mr. SIBERY. Senator, we are vitally concerned about the rapid increase in health care costs. We are concerned about the inflationary impact and infusion of dollars from medicare and medicaid when we have not made substantive changes in how we were organizing and delivering that health care and our ability really to improve the capacity some. Therefore, even though we would not administer the physicians benefit program, we are concerned about anything. Because the health system really has to be viewed in its totality.

I do not believe we are in a position to make judgments as it would relate to specifications with respect to physicians reimbursement, except as it would be within this context of broad concern. I would say in this regard, if I may add one point in the testimony you have already read, our great concern about how care is organized and delivered, now know as an areawide planning approach, and we certainly feel this has to concern itself with the total productivity of the health care system which relates to physician services as well as institutional benefits.

Senator RIBICOFF. Do you think there is an implicit conflict of interest in having a physician or group of physicians own a hospital or extended care facility to which their patients are sent?

Mr. SIBERY. We have had a longstanding commitment to the fact that there must be responsiveness of the institution to the community. Certainly, there is an implied conflict of interest, whether in fact it exists, depending upon the individual and the mode of operation that he chooses to have his behavior characterized. In general, however, it is our association's feeling that health care institutions, in view of the lack of the normal restraint brought about by competition, the law of supply and demand, should as a result of this language be community institutions and controlled by those not having a vested interest.

Senator RIBICOFF. In other words, all language aside, this is wrong?

Mr. SIBERY. Yes; we feel that the implied is, yes. But again you recognize we serve 75 Blue Cross plans and you will find variations, but I am talking with respect to what I would perceive to be the attitude of the board of governors.

Senator RIBICOFF. Since the passage of medicare, there has developed a "for profit chain health facility." You talk about community responsibility. Generally, health had been administered, every phase of it in the United States, by community organizations, religious groups, charitable organizations feeling they were doing it for the benefit of the community.

Now, there has developed profit, stock promoted, chain operations for profit health facilities. Basically, they are devised I suppose to tap the large resources made available through medicare and medicaid.

What is your attitude toward this type of operation?

Mr. SIBERY. Our attitude is, that the ability to influence by persuasion is insufficient; therefore, there must be selected intervention within the health care delivery system with respect to reimbursement, capital construction, and we feel that while these "for profits" may or may not have ulterior motives, that the selective intervention has to relate to the total system. That is why, in our testimony and actions, we are strongly encouraging that the system be forced to be responsive to the community, whether it is a proprietary or nonprofit institution.

Senator RIBICOFF. I am sort of at a loss to understand what you mean by "selective intervention."

Mr. SIBERY. Selective intervention, something that is interposed to intervene between the normal result of action and the result that will come from that. Areawide planning is a selected intervention, and an institution cannot do exactly what it wishes to do. The community looks at it and imposes this restriction.

Senator RIBICOFF. Would this be a State board of health, county board of health? Would it be the Blues?

Mr. SIBERY. We have Federal legislation, Public Law 89–749, comprehensive health planning legislation that established State agencies, areawide agencies, and these are the agencies I am referring to. We feel that we have to go beyond and make those decisions reached by the community effective in changing the health delivery service system.

That is what we mean.

Senator WILLIAMS. In establishing rates for one of the extended care facilities, what factors do you take into consideration? Cost of the building, depreciation, overhead, and so forth?

Mr. TRESNOWSKI. We take all of them into consideration. One of the nice parts of the part A program is we are on a retroactive cost

reimbursement system. As an interim measure for facilitating claim processing, only an interim rate is established subject to final cost determination carried out on rather rigid criteria under policies governed by statute and regulation. It includes depreciation and the factors you mentioned.

Senator WILLIAMS. I can understand it would have to. In line with the question of the Senator from Connecticut, we found several instances where these facilities had been merged into larger corporate structures and maybe they would go public. When these facilities are turned over you find, for example, one which originally cost $1 million and which may have been partially depreciated is turned over on the basis of, say, $2 million. There have been instances where then they figured they should be allowed to depreciate the $2 million rather than the $1 million. How do you work it in these cases to prevent escalating the per diem rate? That is a problem we run into.

Mr. TRESNOWSKI. That is correct. We are aware of some instances of that. Our role there is, to go behind these arrangements to find out whether, in fact, an effective transfer of assets has been made or whether it has not. I think there were a couple of instances reported in the Senate finance report of a year ago concerning these types of things, and one of the Blue Cross plans was involved in that in the State of New Jersey.

We don't take it on face value, but go beyond it in the course of audit to determine whether there has in fact been a change of assets.

Senator WILLIAMS. What did you do about the particular situation discussed in the Finance Committee hearing a year ago?

Mr. TRESNOWSKI. I don't have it in front of me at the moment and don't recall.

Senator WILLIAMS. Are you servicing that particular area?

Mr. TRESNOWSKI. New Jersey, yes. There were two instances cited in that Senate Finance report, as I recall. One was in New Jersey through our plan. I could supply an answer for the committee.*

Senator WILLIAMS. I wish you would supply just what corrective steps you took. As you understand it, what would be the general policy in such cases? That the old cost basis prevails, or would you support escalation clause by just transferring over to the higher cost?

Mr. TRESNOWSKI. Our attitude largely revolves around the legal question. When we have been involved in situations like this, we pressed them as far as we could from an accounting standpoint, and then it is a question of "Was there in fact a change of assets and change of ownership, and so on?"

This is really the criteria.

Senator RIBICOFF. I am curious. What do you find taking place in the "for profit chain health facility operations"? How are those charges compared to charges from the locally or individually owned "for profit" operations in the community. Do you find a differential in the cost?

Mr. TRESNOWSKI. There is obviously a variation in them. I think a chain operation has been more predominant in the nursing home and extended care field. We have not done a specific study on the chain versus the non-profit corporations in their rates. We have examined at some depth the extended care facilities with high interim rates, to

*See letter, p. 312.

find out reasons, but have not gone into correlation if it is a chain. We found a correlation between a hospital affiliated extended care rate, because it is tied into the hospital and higher level of service provided in that case.

Senator RIBICOFF. What do you find?

Mr. TRESNOWSKI. A higher rate.

Senator RIBICOFF. In other words, you find a higher rate in community based extended care facilities tied up with the hospital?

Mr. TRESNOWSKI. Yes.

Senator RIBICOFF. Is that because some of the costs to run the hospital are being allocated to the other?

Mr. TRESNOWSKI. It is not as dramatic a switch. Because it is affiliated, there may be common sharing of, say, dietary service, and so on, and there would be a heavier burden, plus the nursing service. There is a more intensive service in hospitals which would carry over into extended care.

Senator RIBICOFF. What have you found, a rapid extension of associated extended care facilities with hospitals since medicare came into effect, or has that been advancing very slowly?

Mr. TRESNOWSKI. No, there has been a significant increase in hospital relations in these medicare facilities. One of the requirements of the program is, that an extended care facility have, if possible, an arrangement with a hospital. This has been difficult, and hospitals found extended care is part of the full range of services they provide and accordingly felt it would be best for the community in terms of continuity of service that these facilities be associated with the hospital.

Mr. SIBERY. May I speak with respect to our underwritten business in answer to your question? Our studies indicated to us, although there is not enough data yet to draw final conclusions, that with respect to the proprietary institutions, far too often the full range of services are not being provided and therefore the costs, while they may appear to be very much in line, are in fact not indicative of the range of services being provided to the commuuity.

This is a source of concern to us and one of the reasons why we are very anxious to have all institutions subject to some commitment to areawide planning and the range of services which they will provide, so that they can't skim off those services which are less costly to provide and do not provide for the community a complete range.

Senator RIBICOFF. How do you prevent self-dealing where a chain owns a hospital and nursing home, and so forth?

Mr. SIBERY. Are you speaking with respect to medicare or our own business?

Senator RIBICOFF. Both.

Mr. SIBERY. I can speak with respect to our own business. We have been involved, unfortunately or fortunately, in litigation on several occasions where, after finding there was not an arm's-length arrangement, that the board of the Blue Cross plan decided that they would not either accept the institution in the participating relationship, or, if it was participating, would not accept all of the costs in reimbursing.

I think in our private business we are intensifying our efforts even to the point of litigation, if this is necessary, in order to see that

our subscribers' services are reasonable and the community is well served.

Senator RIBICOFF. What do you do with a health conglomerate which runs a nursing home, hospital, and construction company and has a medical supply house?

Mr. SIBERY. You mean in our private business? To the best of our ability, we are surfacing or bringing out these issues. And, again, I could give you an example of where litigation was necessary in order to see the public was served.

Senator RIBICOFF. You do this in the public, you keep saying "private."

Mr. SIBERY. I said I would speak with respect to private.

Senator RIBICOFF. How about the public?

Mr. TRESNOWSKI. We have adequate regulation under medicare and medicaid as it relates to related organizations. Our audit procedures are designed to go behind the arrangements in these types of conglomerates to, first, identify the nature of the certification of the provider to assure that costs are appropriately allocated between them and where services are provided by any other organization under the requirements of "related" organizations, that the costs of the service are the ones that are reimbursed.

Senator RIBICOFF. You think your audit procedures are effective?

Mr. TRESNOWSKI. I think they are generally effective, yes.

Senator RIBICOFF. Senator Miller?

Senator MILLER. Thank you, Mr. Chairman.

I wanted to ask the witnesses about the recommendation appearing on page 12 in which you recommend that in the interest of certification the method of allocating provider costs be revised to a per diem cost basis.

I had an amendment on that a couple of years ago with respect to hospitals, and I understood the American Hospital Association was strongly in favor of this approach.

Mr. TRESNOWSKI. That is correct.

Senator MILLER. That is as a means of avoiding a mass of paperwork in auditing?

Mr. TRESNOWSKI. That is correct.

Senator MILLER. Now, would it be feasible to divide this on the basis of the average per diem cost for comparable service in a particular area, in a particular city or area? Would that be feasible?

Mr. TRESNOWSKI. Absolutely. It could be done by a particular hospital or institution.

Senator MILLER. Suppose you had an area where the high hospital rate was at $100 a day and the low was $50 and the mean was $75. Would it be feasible to provide for a $75 rate in that area?

Mr. TRESNOWSKI. I don't think it would, because it would depend upon why the hospital who had $100 had $100 as its rate. If this were a broad scope institution, a teaching facility with a wide range of services, there may be legitimate reasons for the cost of $100 versus $75 or $50. I think you would have to go on an individual hopsital basis to develop the per diem.

Senator MILLER. That is what we were trying to get away from, all of this auditing and all of this comparing, and to arrive at a per diem cost basis by area.

Now I want to make sure I understand your recommendation. I had an impression that this might work on an area basis, but I take it now you are talking about a per diem cost basis for each provider.

Mr. TRESNOWSKI. That is correct, adjusted for factors which could be common to common homogeneous groups of hospitals. You want to take the per diem of that institution and apply an adjustment factor developed for groups of hospitals, but it would have to be on an individual basis. You wouldn't have to do, for example, a hospital by hospital study of nursing services. You could do this on a group basis.

Senator RIBICOFF. Off the record.

(Discussion off the record.)

Senator MILLER. What we were trying to do in that average per diem in a certain area was to insert in the incentive factor which is so elusive. Would it be feasible to provide for the average in an area on a per diem cost basis, provided that where there is a charge by a provider in excess of the average, that this must be substantiated to the satisfaction of the administration? And that would give them opportunity to actually prove their case, but it would be a real warning to them that they had better be well audited when they exceed the average in the area.

Mr. TRESNOWSKI. That is right. I think what you are talking about is the target rate concept of reimbursements. And I didn't realize that is what you had reference to. That is a method developed and under experimentation at the moment in several locations.

Now if you are talking about a target rate with opportunity for incentive below and above target rates, we agree. We think it would be a good way to go and experiment with it. We don't know what the result would be, but it ought to be pursuant. With that qualification, we would be in favor of it. Our recommendation specifically was a change in the present method of paying hospitals under medicare and medicaid on an immediate basis to eliminate the vast amount of paperwork connected with the RCCAC approach.

Senator MILLER. This leads to the second question. You referred to your support of experiments of the demonstration process developed in the Senate prospective rate. This experimentation is with the target concept and that is going on right now?

Mr. TRESNOWSKI. Yes.

Senator MILLER. How wide is the experiment in that particular area?

Mr. TRESNOWSKI. There is an experiment going on in the State of Connecticut in cooperation with the Connecticut Hospital Association, Connecticut Blue Cross, and the Social Security Administration with target rates by department, meaning a department in a hospital and they establish target rates over a period of time to determine how they turned out.

There is a target rate experiment that was to begin in the city of New York which has not started as yet and is still being negotiated, which would be a target rate by groups of hospitals.

There is a target rate, I think in, Cleveland, Ohio, with Cleveland Blue Cross, which has not been participated in by Social Security Administration but is being developed by the Cleveland Blue Cross plan.

Senator MILLER. That is good enough. How long have these been going on?

Mr. TRESNOWSKI. Connecticut officially began about 6 or 9 months ago, and Cleveland was about a year ago, and New York, as I said, has not started yet but are still in process of negotiating development of that. You will hear testimony a little later from the representatives of the New York City Blue Cross and they can speak more specifically.

Senator MILLER. How long do you think the test trial period should go before you can arrive at a firm conclusion?

Mr. TRESNOWSKI. There is a set program for evaluation of these experimental programs, Senator Miller, and I am not sure exactly what it would be. I would guess they would need at least 1 year under their belt before they would have an opportunity to evaluate and measure it against the criteria established.

Senator MILLER. What other things should be experimented on with a view to developing incentives?

Mr. TRESNOWSKI. You will be hearing later on from Mr. Thomas, Los Angeles Blue Cross where they have developed an approach to incentive reimbursement related to labor production standards, which is in effect a target rate, but geared to the personnel factor in the hospital, which is a significant amount—about 72 percent.

The Associated Hospital Services in New York, New York Blue Cross, will present their proposal for a prospective rate related to cost of living factors from year to year.

Philadelphia Blue Cross also.

Senator MILLER. Pardon me. On New York, I am not sure I understand the incentive feature of that cost-of-living study.

Mr. TRESNOWSKI. Well, I am not sure I will be that specific. But it relates in this fashion. If you determine what last year's costs are, for example, and you apply a factor, an anticipated factor for cost of living you pay on a prospective basis in accord with the rate determined. If you end up the year and the provider comes in under it in terms of his costs under what you paid him on the prospective rate, you would permit him to keep a portion of that difference as an incentive for doing a good job.

If he came in over that rate, you would give him an opportunity to be heard for the reasons why he exceeded the rate with an opportunity to be paid a portion of the amount of excess over that.

Senator MILLER. That is sort of a modification of the target rate?

Mr. TRESNOWSKI. A modification, yes, sir; it is.

Senator MILLER. Any other approaches?

Mr. TRESNOWSKI. Philadelphia Blue Cross has incorporated in their reimbursement agreement a series of incentives related more to production standards, such as effective functioning of utilization review committees and effective accreditation criteria, among others, so they pay an incentive if you do certain things in the process.

Mr. Sibery can talk about Oklahoma and Indiana.

Mr. SIBERY. There are two others that would have as a primary objective placing a provider at risk and that is looking prospectively at what he anticipates doing, not having a target rate for an area, but a target rate for his given institution. That institution, then would be placed at risk.

Indiana has had a controlled charges, as they call it, program for many years. This would have a rate review board and in advance the institution submitting their projections of levels of service, intensity of effort, what have you. And then they would be at risk, because this, except for appeal for unusual circumstances, would be all of the reimbursement.

Oklahoma is tailored somewhat after this and certainly the broad objectives are similar. We strongly believe as it relates to our own privately underwritten business, that increasingly the provider is going to have to be at risk to some degree and that this will require some involvement in prospective rate determination. And experimentation, we believe, is long overdue and must be intensified.

Senator MILLER. Who will sit on the board?

Mr. SIBERY. In Indiana, at the moment this is a board of the Blue Cross plan. What is being proposed and presently negotiated with the Social Security Administration would broaden that board to include a variety of others. That is toward the end of having this be broadly representative of the community and the major purchasers of care as well as providers.

Senator MILLER. Hospitals would be represented?

Mr. SIBERY. Yes; hospitals would be represented and certainly those with no direct or indirect hospital relations as well.

Senator MILLER. What is the object of having the latter in there?

Mr. SIBERY. I think clearly our movement over the years is away from having our boards predominantly made up or constituted of hospital related individuals to where we have had a majority of Blue Cross, or rather a majority of public representatives, in order to assure that the voice of the public is being heard in policy determinations.

Many times the provider or even those who are not paid but have an indirect relationship, such as trustees, look at it in the narrow perspective of their own institution, as opposed to having a broader overview of it representing the total community. We feel by having those not either directly or indirectly related to providers on such reviews will give us a broad overview and will help establish better and more meaningful objectives consistent with that local community need.

Senator MILLER. I recognize, of course, the desirability of having a public voice. But I am concerned that that public voice be knowledgeable and in that connection, and I might say be not only knowledgeable, but be objective. It would seem to me that just appointing public spirited citizens without background would not satisfy the requirement. I would say somebody who is engaged in the accounting practice is knowledgeable and possibly somebody in the law practice or somebody who is familiar with cost methods of arriving at costs. They could give the knowledge or background needed for this to be effective.

Is there any attempt to do that, or is it just some public spirited person who would like to serve but has not the background to do the job we need?

Mr. SIBERY. I would suggest that the record speaks for itself, Senator; that there has been attempt to bring into the decisionmaking process those with specialized knowledge, to assure objectivity as well as opportunity to have those participate who can talk in terms of what priorities they place with respect to health in relationship to

other items. I think both are needed, and I believe our record speaks for itself in this regard; that we have attempted to accomplish these objectives.

Senator MILLER. One last question. Who sets up the board? Who is the appointing authority?

Mr. SIBERY. In Indiana, at the moment, it is the board of the Indiana Blue Cross plan itself, and this is now subject to negotiation. So I don't know what will happen there. One can only speculate. But there will be opportunity as the negotiations appear to indicate for others to have input, including certain units of government, the health insurance industry, and other important segments within the community.

Senator MILLER. Thank you, Mr. Chairman.

Senator RIBICOFF. I wonder if you gentlemen would still remain in the room after you are through testifying here, because the staff will have questions after Dr. Freedman and Mr. Eisenman testify.

(The following communication was received by the committee in answer to questions asked of the preceding witnesses:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., May 6, 1970.

Chief Counsel, Senate Finance Committee,
New Senate Office Building,
Washington, D.C.

DEAR SIR: During our testimony before the Subcommittee on Medicare-Medicaid on April 16, 1970 we were asked to supply our suggestions on:

(1) Experimentation with alternate methods of financing and administering titles XIX and XVIII.

(2) Regulatory authority to the Secretary as it relates to claims review.

The committee also asked for a status report on the action of Blue Cross in the case of the Cherry Hill Realty Corporation and its subsidiaries, which was reported on during the Hearings before the Committee on Finance, July 1 and 2, 1969.

EXPERIMENTATION WITH ALTERNATE METHODS

It is essential that incentives for effectiveness be built into the title XIX adn XVIII programs. This can best be done at the state or local level, with Federal requirements for overall goals, performance standards, program documentation, and evaluation of results. This objective can best be met by use of competing carriers having different objectives that are subject to evaluation and incentive. The principle characteristics would require that:

The programs be administered in each state by at least two different financing agencies (e.g., voluntary prepayment, commercial insurance, medical society, state agency).

Eligible agencies would be certified by the Federal Government as qualified by size and experience, but would participate on a rate basis with selection of carrier open to each beneficiary-household and with open seasons for change of carrier, as under the Federal Employees Health Benefits Program.

Regulation would be at the state level other than for carrier certification. The Federal objective in carrier certification would be towards determination evaluation of standards of performance—particularly on impact upon the health care delivery systems cost and controls.

This approach would provide opportunities for experimentation and for choice. It would create a downward cascade of "risk" and control. If a standard minimum Federal benefit level were to be incorporated, for example, the "pressure" would be on the state to provide that program plus as much else as possible. It would exercise "pressure" on certified carriers to find ways to provide those benefits, and perhaps others, at the lowest cost possible. This would provide incentives

to the carriers to provide maximum benefits at minimum costs, to implement controls of use, and to develop relationships with individual or institutional providers under which similar incentives would be present. This would be especially true when experimental kinds of benefits, or group practice plans, community-service clinics, etc., were developed and available for choice by the beneficiaries. Such choice could provide meaningful demonstrations of the ability of different systems to provide quality and quantity of care under different assumptions and objectives. The system would reverse the more normal one of "how much will it cost to provide such and such benefits" and ask instead the question "how many benefits can you undertake to furnish for the same amount of money that is available to everybody else". The answer would be found in the kinds of choices made by the individuals involved, and the evaluations and critiques conducted by the Federal Government.

Utilization and cost control methods would be essential, but would not be mandated along uniform lines—because this is probably not yet the way to achieve maximum results. Open public competition for support, based on commitments of whatever provider-carrier group backs each approach, and the results actually experienced, can perhaps be more effective in a typical competitive environment than can regulation in these fields.

Administrative control through requirements for documentation and reports of performance, rather than by regulation of operating techniques, and with state supervision would seem desirable.

REGULATORY AUTHORITY FOR CLAIMS REVIEW

Section 1862 of the Act identifies a series of exclusions from coverage which are either specifically identified and clearly understood as representing non-covered benefits or are clearly within the prerogative of the Secretary to define within his broad regulatory authority granted under Section 1871 of the Act. The single exception to this clear mandate concerns the exclusion for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (Section 1862 (a)(1)). The discretionary powers of the Secretary appears to be limited by the specific authorities granted to utilization review committees under Section 1861 (k)(1)(A) and (B) of the Act whereby the utilization review committee is required to provide for the review, on a sample or other basis, of admissions to the institution, the duration of stay therein, and the professional services (including drugs and biologicals) furnished, with respect to the *medical necessity* of the services, and for the purpose of promoting the most efficient use of available health facilities and services.

Since the exclusion from coverage of services "which are not reasonable and necessary for the diagnosis or treatment . . ." parallels decisions on "medical necessity of services . . ." the Secretary must be given the specific regulatory authority, with professional consultation, to establish standards and guidelines covering medical necessity on a diagnosis or other basis to be used in claims review.

CHERRY HILL REALTY CORPORATION

The facts in this case are reported on page 273 in the Hearings before the Committee on Finance, Ninety-First Congress, July 1 and 2, 1969.

Blue Cross is in essential agreement with the opinion of the Office of General Counsel of HEW in this case. Accordingly, our audit of this corporation for calendar 1968 shows adjustments as follows:

(1) Reduction in depreciation expense of $47,000 using asset values recorded prior to the appraisal as the basis for computation.

(2) Reduction in interest expense of $266,000 in recognition that interest pertinent to the promissory notes issued for the purchase of stock and payable to the former owners is not a reimbursable cost item.

We hope this additional information is helpful in the Committee's deliberations.

Very truly yours,

BERNARD R. TRESNOWSKI.

STATEMENT OF MARK FREEDMAN, M.D., AND HENRY EISENMAN, ASSOCIATED HOSPITAL SERVICE OF NEW YORK—BLUE CROSS

Senator RIBICOFF. We will next hear from Dr. Freedman and Mr. Eisenman.

Dr. FREEDMAN. Senator Ribicoff and distinguished committee members, I am Dr. Freedman, vice president of Associated Hospital Service of New York. With me is my associate, Henry Eisenman.

Our Blue Cross plan serves the southern 17 counties of New York State. Of the 11-plus million people who live in our area, we have 8 million subscribers enrolled.

With your permission I would like to discuss today the hospital reimbursement formula currently in use by our Blue Cross plan.

Even though it is new, having only become effective January 4, 1970, we believe that some of the innovative features of the formula deserve your attention, especially in light of the interest which has been expressed in the formula by your staff and by the Social Security Administration.

I. PROSPECTIVE RATE SETTING

We have gone to the prospective rate setting in an effort to insure greater predictability of payment, both to the payor and to the provider of service, and in recognition of the fact that prospective rate setting carries with it the element of budgetary control which hopefully will create a greater sense of prudence in program development and to provide an incentive to providers for containment of cost.

II. PEER PERFORMANCE COMPARISON

We have retained in the formula the element of hospital groupings by program content; that is, teaching centers, and so forth, geography, and size. These groupings are used to develop group averages against which individual members of the group are measured and maximums set to protect against aberrant situations.

III. USE OF ECONOMIC INDICES AS A CONSTRAINT

We have built into the formula a method of relating the development of perspective rates to a series of selected and weighted indices which it is hoped will, over a period of time, gradually bring the hospital economy more in line with the general economy.

IV. CAPITAL FUNDING

In the formula we have provided separate methods of handling depreciation for those hospitals which can demonstrate the ability to fund their depreciation and who wish to do so; and community pooling of capital funds provided for those institutions unable or unwilling to fund their depreciation.

V. INCENTIVES

The formula contains an incentive for the purchase of labor-saving equipment and for improved utilization of facilities. The pooled funds described in paragraph IV, above, are used to fund these incentives.

VI. PENALTIES

Penalties are provided for worsening utilization of facilities and for exceeding peer group maximums.

VII. APPEAL

A formal system of appeal is provided for the providers to assure appropriate equitable treatment under the formula and to give recognition to unusual developments within any single hospital or group of hospitals.

Mr. Chairman, rather than take the time of the committee, I herewith deliver to you a copy of the formula referred to, together with an exhibit, marked "A," which is a description of indices utilized to project hospital payment rates. Of course, we will be happy to supply your committee with any number of copies or such additional information as you may desire.

Earlier in my testimony I referred to the newness of this formula. I wish to assure you that we are aware that this formula has not been generally accepted with open arms by our 200 member hospitals. It has been approved by the State department of health as meeting the intent of the hospital cost control law, which I shall refer to later. There will be continuing discussions on various elements of the formula with both the State and the providers with ultimate resolution of some of the technical problems concerning the formula's implementation.

We do not offer this formula as a panacea for the medicare, medicaid problems of reimbursement. However, we feel that a number of the elements contained in it could with varying degrees of applicability be used in the development of a series of approaches to the problem of medicare, medicaid reimbursement.

The formula which we have discussed is the natural outgrowth of a series of developments which are unique to New York City and New York State areas.

1. Inherent in our formula is a background of cost reimbursement for 9 years which has provided to our Blue Cross plan a reservoir of cost data by institution, by group of institutions, and for the area as a whole which to my knowledge is not duplicated anywhere else in the country.

2. The Greater New York area has had a hospital review and planning council for more years than any other area in the country.

3. Hospitals are licensed by the State of New York and over the years the hospital codes of the State of New York and of the city of New York have served as a model wherever licensing has been considered.

4. By law all construction of health facilities in New York State, including major renovations, have since 1964 required the approval of a local hospital planning council and the ultimate approval of the New York State Health and Hospital Planning Council.

5. As of July 1, 1969, a cost control law was passed in the State of New York which provides that the State commissioner of health must certify that rates of payment to hospitals are reasonably related to the cost of efficient production of the services being purchased both by Blue Cross for its subscribers and for the State under its title XIX pro-

gram. This law which became effective January 1, 1970, was the immediate stimulus to the promulgation of the formula which we have presented to you today.

I would like to call to your attention another fact in New York State which has had a major impact on the development of our reimbursement formula.

In 1967, with the cooperation of the Social Security Administration, the Hospital Review and Planning Council, the local hospital associations and the United Hospital Fund, it was possible for us to develop a uniform financial report and a uniform statistical report for the hospitals of our 17 counties. Since that date, the commissioner of health of the State of New York has joined with us and now accepts the data in the reports referred to as sufficient for the development of reimbursement rates under medicaid. In fact, by contract with the State of New York we now use the computer capability of Blue Cross to develop from the one basic report from medicare reimbursement rates, medicaid reimbursement rates for the State of New York and Blue Cross reimbursement rates, and from this data also provide to the planning agencies basic data for their purposes.

I have here, Mr. Chairman, a copy of the Uniform Financial Report and of the Uniform Statistical Report and samples of the computer outputs developed by the program, and of course should you wish any additional data we shall be happy to make such available to your staff.

Senator RIBICOFF. I was going to ask Senator Long to ask the first question. But before I do, I think I should state the staff informed me in their opinion you are one of the most outstanding intermediaries in the whole Nation; that you are innovative, and what you have done and are doing takes a lot of courage. And I want to publicly commend your organization for the job it has done.

Dr. FREEDMAN. Thank you, Senator.

Senator LONG. Does your reimbursement plan pay hospitals' costs at the average cost to provide the service? And, if not, what limitations are placed upon such costs?

Dr. FREEDMAN. Sir, if I may first make an answer to Senator Miller, we do on sales of facilities, call both parties to the sale in before the sale and advise them of what we will pay after purchase, without regard to what has been paid for the asset.

In our formula, responding to your question, Senator Long, we provide maximums for group extremes to the extent that we will not pay anybody within a similar peer group more than 115 percent of the average within that group.

We have penalized hospitals repeatedly under this provision. We have been party to a large number of lawsuits from providers and, fortunately, we have won them all in the State of New York.

Senator LONG. You have won all of the cases?

Dr. FREEDMAN. Yes, we have won all of the cases to date for application of penalties under the provisions of our past formulas, and we may be challenged on this new formula, sir.

We have other restrictions. In the new formula, for the first time we are insisting on what we call the prudent use of capital funds. In other words, the institution must fund its capital payments and use them for community-approved projects or if they are not willing to

fund their capital payments under our formula, we pool all of these such capital funds and they are made responsive to a group of outstanding citizens appointed and selected for the purpose of insuring that the capital funds are used in the community's interest.

Senator Long. Have any other Blue Cross plans indicated a serious interest in implementing controlled reimbursement formulas such as yours?

Dr. Freedman. Sir, our formula is quite new, as I stated. We have had numerous inquiries, great interest expressed in it. Senator, however, I call to your attention the law of the State of New York is on our side and on the side of the beneficiary and subscriber. There are many States in which the attitude of the State bodies is not, or rather the climate is not as propitious for implementation of a formula such as ours.

Senator Long. As I understand it, the Greater New York Hospital Association sponsored a study critical of the price index you used as to limiting acceptance of hospital costs. And what is your response?

Dr. Freedman. The Greater New York Hospital Association retained the services of an outstanding economist, and he has submitted to that association two preliminary reports which have been offered for comment. And it is our intent to be reasonable and if the economist can find a better index, we will go forward to the State health department for a change in our indices. We do not think we have done a perfect job, sir. Any time one selects indices, one is arbitrary.[1]

Senator Long. Why have you found it necessary to establish detailed controls on your reimbursements to hospitals?

Dr. Freedman. Sir, in the period of population expansion in the suburbs, we found that the communities were suddenly finding themselves with large numbers of proprietary hospitals and they were springing up without regard to community planning, without regard to community need. And as a control, we used our reimbursement process to force community planning, working together with the State and local agencies of government.

Senator Long. What have hospitals not done on their own to control costs? In other words, what do you think hospitals have failed to do to control their costs?

Dr. Freedman. Sir, the budgetary process has been, over a period of years, alien to most hospital operations. We feel that the formula we have projected gives incentive and target for the use of the budgetary process and its constraints. We feel this is a worthwhile effort on our part.

Senator Long. Are you satisfied with the quality of utilization review by hospitals and extended care facilities? And, if not, what are the problems and what solutions would you recommend?

Dr. Freedman. I am not satisfied. The quality of utilization review by hospitals is from very poor to good or fair. The quality, sir, depends on the devotion of the individuals selected for the committee in great part, and the organizational structure within the hospital.

I agree wholeheartedly with the recommendations contained in the testimony given by Mr. Trensowski that claims review, per se, should be an intermediary responsibility; that patterns of care review and ad-

[1] See app. A.

vice should be appropriate functions for hospital utilization committees.

Senator Long. Do you have any recommendations for resolving the problems connected with level of care determinations for patients in hospitals and extended care facilities?

Dr. Freedman. Mr. Chairman, nothing is more perplexing and more difficult than the adequate description of levels of care and their interpretation. I would pray for more clarification, and incorporation of this clarification and definition into law rather than intermediary letters or administrative advice.

Senator Long. That is a job for us to do, and I appreciate your suggestions.

Now in the absence of controlled reimbursement of hospitals, such as in your formula, what do you foresee happening to the costs of hospital care?

Dr. Freedman. Regardless, sir, of our formula or any other, along with the cost of care going up, the question is "How high is the jump?" I think every device that we can manage—and we have not come to the end of the road, I am sure, in our area—must be considered. But I don't hold out any great hopes that cost increases will stop.

Senator Long. Many cite increased labor cost as the prime cause of hospital cost increases. Do you think hospitals can make better use of present personnel to increase productivity to any significant extent?

Dr. Freedman. Sir, I am sure that is so. One must remember that the hospital structure has too many bosses within its structure. Services are ordered by doctors, controlled in part by nurses, and controlled in part by administration legislated under hospital codes, local, State, and Federal. And there are many forces at work on how the personnel are used in the hospital. I think the most encouraging sign I have seen is the increased use by hospitals of engineering staffs, personnel engineering staffs. And I think if we put enough pressure on the hoospitals through budgetary controls, this practice will grow. There is meat there. I can't estimate how much.

Senator Long. What do you think of the idea that we might experiment in trying to hold down costs by simply paying certain carriers, you or someone else, a certain amount of money multiplied by the number of people for whose health you have responsibility? We could try to allocate an amount that would permit you to make a profit and hope that you could save something out of it so you would make even more profit if you can do the job efficiently?

Does that kind of appeal to you? Do you think that there is anything worth trying in that suggestion as a way holding the cost down and to put pressure upon the provider and intermediary to help keep the cost down?

Dr. Freedman. Mr. Senator, I would like to echo Mr. Sibery. We are most willing to experiment, most willing to experiment. The difficult items are the basic assumptions that must be built into the actuarial considerations. This cannot be done easily, as the committee knows.

Senator Long. I have seen some private hospitals in my own State where the length of stay is half as long as it is in a publicly operated hospital, and that made me think it might be worth trying on an ex-

perimental basis—to take the staff that runs the private hospital and put it in charge of the public hospital for a while and see what they can do with it. At least they might be willing to offer advice and be helpful in suggesting how greater efficiency could be achieved.

There are just a lot of things that can be done in the medical care field to save money. During the course of this morning's testimony, Senator Ribicoff and I discussed that in more efficient hospitals the doctor is not the one that draws the blood in a blood test or checks your blood pressure or heartbeat, or even takes a cardiogram. The hospital nonphysician personnel do that work and the doctor then only sits with the patient to see to the patient's problems and he has all of that other information in front of him, which results in tremendous savings.

I wonder what you can tell us as to ways to go about obtaining the most efficient use of people where we are paying for their services?

Dr. Freedman. Mr. Chairman, for many years we have, together with a prepaid group practice program, known as Health Insurance Plan of New York, sold insurance, we selling or servicing the hospital part and they selling the medical services part. We have experimented with them on incentives for reduced hospitalization and these incentives, to me and to our staff, are encouraging.

I agree with you that we must multiply this type of experimentation or we are lost.

Senator Long. Now, in the kind of work you are doing, do you employ competent doctors as medical advisers?

Dr. Freedman. Sir, that is an embarrassing question. I happen to be a doctor. I believe that we have some of the very best in the field of insurance administration.

Senator Long. Don't all intermediaries have medical doctors to advise them with regard to how they should handle these functions?

Dr. Freedman. I can't speak to the point, but I can say the doctors I have met have been very devoted and concerned.

Mr. Chairman, I would like to ignore the advice that was given on how to testify and deliver to your staff our newest effort in the field of utilization control. We believe that wide public exposure of what is going on may have as dramatic effect as anything else that is possible. And we have begun a series of community regional conferences in our area; we called together the political leadership of the community, the hospital trustees, the administration of hospitals, the chairmen of their medical staffs, the medical society representatives, and put on a seminar. We furnished to them as complete a story of the events that are occurring in their locale—in this case it was three counties and in this other case here two counties—that we can possibly put together.

In these documents, we publicly announced the rates that we pay hospitals, the rates we pay hospitals for medicare, the length of stay by selected procedure of every hospital in that area, the profit or loss of that hospital. And while we have not seen the results of this, we are very hopeful.

Senator Ribicoff. If you yield?

What you did, did this get press and television coverage?

Dr. Freedman. We invited the press, but it got almost no coverage.

Senator RIBICOFF. That is one of the great tragedies. Like you say, it is only when there is public exposure of the programs, and you have billions and billions of dollars involved and you have 20 million people involved and you have a tax concern, a rate concern for everyone on social security. Yet here is something you bring out that affects the whole community and does not get coverage.

I yield.

Senator LONG. You are paying for an enormous amount of medical services in the New York area for a great number of people. It seems to me one of the advantages of having private insurers as intermediaries in this area would be that you have a parallel interest in helping to see that we have a good program.

Now, with the amount of care you are paying for under your private plans, as well as your Government programs, wouldn't that put you in a position to say, if you want to, to say, "This is really what we ought to pay for and this is really all we are going to pay?"

Dr. FREEDMAN. We are accused of that constantly.

Senator LONG. It seems to me that is the way you ought to do business.

Now, it does not bother me to find doctors making a lot more money than I am being paid as a U.S. Senator; that does not bother me at all. If a doctor makes $60,000 a year and I am being paid $42,000, that does not bother me, provided we are getting most efficient use of his services. But if we are paying for that fellow to be doing work that a hospital corpsman could be doing and as a result he is not caring for the number of patients he should be caring for, it does concern me. Because we are not getting our money's worth in that case.

I take it that you are trying to see to it, in cases of that sort, that we get the most of what we are buying with our money.

Dr. FREEDMAN. We try to.

Senator LONG. I want to thank you for the good work you are doing.

Senator RIBICOFF. Dr. Freedman, out of curiosity, do you practice medicine, or is this a full-time job you have now?

Dr. FREEDMAN. Yes; this is a full-time job.

Senator RIBICOFF. From your experience, you and your associates, would you make recommendations in the changing of the law or change of regulations concerning medicare?

Dr. FREEDMAN. I subscribe to those which BCA offered in their testimony. I think they are excellent, and I think their order of priority is a correct one, sir.

Senator RIBICOFF. Do you have any suggestions besides the one you are now offering in which there could be some pilot or experimental programs of alternative methods of care or payment or procedures that would be worth trying?

Dr. FREEDMAN. I would like to answer your question by answering a question that Mr. Miller had raised. Senator Miller has raised the question of our effort to have an experimental program under medicare reimbursement never got off the ground, sir. That was because it was an optional program and there were not sufficient providers willing to take the risks that we felt they should have taken under the experimental program.

I do not believe that optional entrance into experiments is in the best interest of anybody. I think that you can have experimental programs, but I think there should be clear guidelines as to who shall or shall not participate, and as long as it is left to the option of the provider, I can't see it working well.

Senator RIBICOFF. You have been operating on this program since January 1, 1970, and how many returns are in, shall I say?

Dr. FREEDMAN. Let me put it this way. We are under severe criticism by most of our providers for doing what we think is a good job. This will ultimately come to hearings before the State health department and we believe we will be upheld, sir.

Senator RIBICOFF. But when would you know? I mean January—well, when did the returns start, a month or 2 months? When do you start receiving the picture?

Dr. FREEDMAN. We require quarterly updates of information. I think to get a clear indication will take 1 full year of experience, sir, unfortunately.

Senator RIBICOFF. Senator Miller?

Senator MILLER. Thank you, Mr. Chairman.

Dr. Freedman, I enjoyed very much your testimony which is very knowledgeable and very responsive. I might say I would share in this point of view that you didn't get better press coverage. If you have any inclination to consult with the Vice President, I might be able to help you.

Dr. FREEDMAN. Sir, the Social Security Administration has been very supportive of our efforts and attended our conferences and think we conducted good conferences for their purposes. Members of Social Security Administration have come up and sat with us and think it will get wide exposure.

Senator MILLER. I would like to explore further a question raised by Senator Ribicoff. You mentioned some 200 hospitals are in the group that are in your plan. Do they have an association of their own?

Dr. FREEDMAN. There are five associations within our area—two, I am sorry.

Senator MILLER. Now before implementing a formula such as you discussed before the committee, I take it you probably talked this over with some of these hospitals?

Dr. FREEDMAN. This year, we did not discuss the formula with anybody except ourselves.

Senator MILLER. Would there be a reason why you might not take them into your confidence a little bit, so they feel they have a part of the action, perhaps, and might be able to make a contribution?

Dr. FREEDMAN. Frankly, there was a time constraint. Negotiations with hospitals are usually long and drawn out. As a matter of fact, the discussions we are now having concerning technical change may take as long as a year. We were under a legislative constraint to be ready to operate on January 1, 1970.

Senator MILLER. You mean New York legislation?

Dr. FREEDMAN. Yes, New York legislation.

Senator MILLER. I can understand that. Since this time, since this went into effect, no doubt the trustees and administrators have been discussing with you possible changes?

Dr. FREEDMAN. Correct.

Senator MILLER. Have they done it individually or as a group or association?

Dr. FREEDMAN. We asked the hospitals to nominate representatives to an advisory committee appointed by ourselves, and they did so. There is an advisory reimbursement technical committee nominated by the various associations from which our board selected those representatives that they felt most capable.

Senator MILLER. Now, has this advisory committee made any written comments on this plan?

Dr. FREEDMAN. They have, sir. They have submitted a statement, the proprietary hospitals rather have submitted a statement, and we have, in turn, commented on their statements. That is as far as we have gone, in writing.

Senator MILLER. Will you have copies of their statement and response?

Dr. FREEDMAN. I do not have, sir. But we will be glad to furnish them.

Senator MILLER. I would like to suggest to the chairman that these ought to be included in the record.

Senator RIBICOFF. Without objection, the statement and response will be in cluded in the record.*

Senator MILLER. Thank you.

And thank you, Doctor.

Senator RIBICOFF. Mr. Hansen.

Mr. HANSEN. No questions.

Senator RIBICOFF. I again want to thank you, gentlemen, for coming and commend you for your courage and willingness to take the bold, tough step. It is my feeling we need more experimentation as shown by you, and I might repeat to you it is my hope that after we get recommendations that the Finance Committee and the Congress will authorize HEW to undertake some experimental pilot programs throughout the country for alternative methods of trying to make this work.

We are all due on the floor. I would appreciate, though, if you two gentlemen would remain with the other gentlemen from the Blue Cross Association to answer questions that the staff may have. I would appreciate it if you would remain for a few moments.

STAFF. If it is agreeable, will the Blue Cross Association people and the New York group remain at the witness table.

The first questions are for the Blue Cross Association. What benefit flows to medicare from permitting provider selection of intermediaries? It has been reported to the Staff that some providers threaten to change intermediaries who are not accommodating. Would that type of activity be avoided if the Secretary of HEW designated intermediaries under part (A) as he does carriers under part (B)?

Mr. TRESNOWSKI. We think the Secretary under the statute has authority to make a determination as to whether an intermediary can serve effectively and efficiently when nominated by a provider. We feel when a provider requests switches of intermediaries, the Secretary has authority to make a determination as to whether the switch is in the best interest of the program.

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[1] See app. A.

So, we feel that the Secretary has ample authority to carry out these responsibilities. We also feel that the provider nomination has been good for program, it has given the provider an opportunity to select that intermediary, that he has existing channels of communication, effective provider relationships, and so on, so there has been a positive result.

STAFF. The Social Security Administration undertook a series of validation surveys which indicated some Blue Cross plans were making improper payments to extended care facilities. Has the Blue Cross Association made similar surveys in local intermediaries and, if so, what were your findings?

Mr. TRESNOWSKI. There were 18 so-called validation visits made to Blue Cross plans. As of today, we have seven of those reports from the Social Security Administration. The Blue Cross Association has conducted 52 onsite visitations, seven of which were followup visitations in connection with the same type of validation framework.

The findings in the seven that we have gotten indicate a variety of instances of nonapplication of the guidelines concerning level of care, questions of performance in terms of the audit function.

These have all been visited and corrective action has been taken by the Blue Cross Association in addition to the 52 that we conducted on our own.

STAFF. A substantial number of Blue Cross plans, according to social security data, have failed to properly carry out the process of securing audited cost reports of hospitals and ECF's in effective fashion. They are not following up with terminated providers to assure proper recovery of Federal funds; fail to require completion of cost reports and audits in reasonable time; many reports contain many errors; and essentially not questioning costs on the basis of being excessively high.

How long are you giving individual plants to improve performance of these important functions before you propose to terminate them?

Mr. TRESNOWSKI. There was a series of comments and let me work backward because I remember the last first. The question is, "Have Blue Cross plans been taking action in the area of reasonable cost determination? We operate clearly under the principle of reimbursement under Government regulations. Every cost report that is finally settled comes through the Blue Cross Association before transmitting to the Social Security Administration.

We presently return about 40 percent of the cost reports to Blue Cross plans for corrective action. The other part of your question had to do with, "What have plans done to meet these requirements?"

I don't think that the burden or responsibility for incomplete cost reports, timely filing, delays in audits, delays in settlement, lies with the intermediary. As indicated earlier in the testimony, there is a long history associated with the reimbursement function of the program. We have made some major strides in the last 9 months. As of March 30, we have filed with the SSA well over 9,000 cost reports.

This as a 50-percent increase in the last 6 months alone. Why has it happened? It has happened because a number of important steps have taken place.

First, a series of penalties were applied to nonfiling of cost records which had a major effect. Another change on the part of the inter-

mediary is to conduct a limited audit program; another was to administer a shortcut adjustment form; and, another was to settle the cost report without signoff by the administrator on an appeal basis.

STAFF. Are you saying basically that the problems in delayed cost reporting and so on and other inefficiencies are those of the program and that Blue Cross plans have not been negligent?

Mr. TRESNOWSKI. No. I hope I included in the comment there have been fundamental problems in capability of Blue Cross to develop adequate audit staff to carry out these reports and there has been difficulty there.

STAFF. In your statement, you recommended that a physician's certification be accepted as presumptive evidence of covered care, presumably in an extended care facility. Would you recommend that the certification be accepted as presumptive evidence where the physician is an owner of the facility involved?

Mr. TRESNOWSKI. Where the physician is an owner of the facility involved?

STAFF. Yes; or part owner?

Mr. TRESNOWSKI. The reference we made had to do with section 1814 and it specifically referred to inpatient hospital service. The same requirement does not now apply to an extended care facility.

The only point we made there was the statute mandates our acceptance of the certification and we were simply asking that it only serve as presumptive evidence based upon our subsequent review of the claim.

We would make the same comment with regard to extended care facilities, whether it is an owner or nonowner physician, and this ties in with the strong feeling that the claim process ought to be used more effectively as utilization control.

STAFF. Are you saying there that it would not affect the utilization review mechanism if you accepted the physician's certification as presumptive evidence of covered care?

Mr. TRESNOWSKI. I am saying that it would. I am saying there are two provisions, 1861(K), which describes how the committee is to function, what accountabilities are, plus 1814 describing the certification and recertification process and have been confused with our obligations to administer exclusions under 1862 of the act.

We have had difficulties in relating the providers to the claim process. What we say is Congress ought to clarify section 1862 of the act to be administered under standards and criteria of claims review, not withstanding the certification of the physician or activities of the utilization review committee.

They only may support the claim review process.

STAFF. Yesterday, the committee took testimony from witnesses who suggested that the skilled nursing care requirement in extended care facilities, be repealed. Do you have any observation on that suggestion?

Mr. TRESNOWSKI. We do not agree with that recommendation. I should qualify, simply because the program has to operate within certain financial limits and there have to be lines drawn somewhere, if it is not skilled nursing, you have to draw it elsewhere.

I don't have absolute commitment to skilled nursing service, but it has worked. It has been difficult, but it worked.

STAFF. If that concept were adopted, would it downgrade the level of care that is provided in the extended care facility and turn the intensive care facility into a custodial convalescent home?

Mr. TRESNOWSKI. I wouldn't use that word "downgrade." I think it would change the benefit. The benefit is an extended care benefit requiring continuous skilled nursing care, a new concept in health care, certainly, but a concept that has been under operation for 3 years. If you took it away, you would change it to something else.

STAFF. If I understand the suggestion made yesterday, these proposed changes in the statute, of relying solely on certification and of eliminating the requirement of the skilled nursing care, would be offset by tightening up on the other side by cutting the 100 days of care in half.

Now, if you tighten up on one side and loosen up on the other side, what are you doing to the net cost of the program?

Mr. TRESNOWSKI. It is not a plus-one correlation, because, in the first case, you are changing the benefit. In the second case, after you change the benefit, you just restricted the scope of the benefit. It is not the same thing. You are not providing extended care benefits by eliminating continuous skilled nursing service.

You may come out the same in dollars but you have changed the benefit.

STAFF. Do you have any experience on the number of days of care that are rendered in extended care facilities that would enable you to judge whether or not cutting the period in half would result in any savings of money if you loosened up on the coverage criteria?

Mr. TRESNOWSKI. I do not have information readily available on that. I would speculate simply that if you reduced the criteria for covered care, your use would go up. That is because this is not necessarily a medical problem that is faced but a social problem.

A major significant policy is here as a matter of fact. What do we do with the aged population who have a need for some type of either custodial or institutional or shelter care service?

Now, if the medicare programs choose to meet this need, so be it. At the present time under the law, it has chosen to meet a specific medical need and not the social one.

STAFF. What information does BCA have as to the amount being paid by medicare to hospital based specialists such as radiologists and pathologists and to what extent if any has the medicare reimbursement method increased the compensation of those specialists?

Yesterday, the carrier group in essence recommended that the law be amended along the lines of the Douglas amendment which the Senate passed in 1965. With respect to the hospital based specialists, precisely what do you know about their total compensation?

Mr. TRESNOWSKI. In testimony before this committee in the latter part of 1967, we identified that the provision of payment for hospital based physicians under part (B) funds had apparently stimulated an increase in costs. As a result, the 1967 amendments provided for the combined billing option for pathologists and radiologists.

An interesting thing has happened as a result. A vast majority of those have chosen to go back to combined billing and this has given the intermediary an opportunity at the time of final settlement to make a determination as to whether the amounts paid out of the part (A) or

(B) funds are related to the compensation received by those gentlemen, so it has given a greater opportunity for control.

STAFF. Do you have precise data as to the specific amounts going through the program to specific specialists?

Mr. TRESNOWSKI. Where the radiologist and pathologist has elected combined billing, we do. Where he has not, and he continues to split the bill, the portion of his billing submitted to the carrier, we would not then have that information.

STAFF. No one seems to have that information.

Mr. TRESNOWSKI. We do have the administrative components and under combined billing we have both.

STAFF. The staff strongly recommended in its report simplification of the cost finding and auditing process in medicare. Dr. Freedman described what New York City has done. Do you have suggestions beyond the approach of the New York City plan with respect to simplification of cost finding and auditing other than your average per diem recommendation?

Mr. TRESNOWSKI. No, we support that. We think there are advantages to the cost reimbursement system which includes cost finding and determination of allowable costs. Our concern was with the specific method applied in the medicare program.

STAFF. I don't recall if Senator Williams asked you, but what is your judgment as to the relative cost of going to your adjusted average per diem reimbursement as opposed to the present method of medicare reimbursement? Would it be greater, less, or about the same?

Mr. TRESNOWSKI. Up until January 1 of this year, one of the options available to all-inclusive rate providers was payment on the basis of 93 percent of per diem.

While 93 percent was chosen on the basis of studies done by the Social Security Administration actuaries as representing the differential between full per diem and the amount we paid under RCC, we don't know exactly what the adjusted per diem would be.

I suggested it would be perhaps in the range of 95 to 96 percent to Senator Williams. The margin that we are projecting here would not be significantly different from the RCC approach but administrative cost savings would be sizable.

STAFF. But do you think it ought to be examined carefully on a sample basis to determine the differences?

Mr. TRESNOWSKI. Absolutely.

STAFF. Social Security conducted a survey in 1968 which showed that 47 percent of the hospitals surveyed were not conducting sample reviews of admissions. Now, that is a statutory requirement. Exactly what is BCA doing to assure that such statutory requirements are being complied with in each intermediary area?

Mr. TRESNOWSKI. In the latter part of 1966, about 5 months after we entered the program, the Blue Cross Association prepared a detailed checklist performance evaluation outline for the member plans to apply in evaluating certification, recertification, and the statutory UR requirements.

We have supervised the plans in the carrying out of the checklist requirement. We reissued an update of that information to assure that our obligations in that regard are being carried out plus the advice to the State health department where we find noncompliance.

STAFF. Do you have sample audits on these plans?

Mr. TRESNOWSKI. I do.

STAFF. Has the Blue Cross Association evaluated the New York City reimbursement formula and have you taken any position on it?

Mr. TRESNOWSKI. We have evaluated it in some depth. We spent considerable time with the New York plan going over it. I think Dr. Freedman pointed out earlier that formula was developed in specific response to a State law and that the aspects of that formula, the detailed aspects are related to the peculiar conditions in New York State.

We think that that formula does meet the criteria that we established, it does provide simplification and predictability and we think there are incentive features built in.

STAFF. Do you think the formula is capable of being administered in most areas of the country?

Mr. TRESNOWSKI. We had a long and, I think, bitter experience in the administration of one type of reimbursement system, RCCAC throughout the United States on a variegated hospital system. We would not recommend in favor of a single method.

We think there ought to be experimentation pursued vigorously to find out if varying schemes can be applied.

STAFF. Exactly what is each Blue Cross intermediary doing to insure proper utilization review in each area? Precisely how does each of your plans determine that every hospital has a properly functioning and effective utilization review program?

Mr. TRESNOWSKI. I think it was partly answered by the previous answer. Based upon this extensive checklist we prepared in the latter part of 1966 in an evaluating sense, it gives a step-by-step procedure that each plan should follow within each hospital to evaluate compliance with certification activities.

STAFF. Are you satisfied that, in fact, in each plan area the hospitals are properly functioning within the utilization review plans?

Mr. TRESNOWSKI. The plans are not satisfied and reported back and we find widely varying performance. Dr. Freedman indicated very poor to fair and good. Our evaluation of it shows there are excellent functioning utilization review committees.

STAFF. How would you evaluate institutional review nationally?

As Dr. Freedman pointed out in the New York metropolitan area, he rated his from poor to fairly good.

Mr. TRESNOWSKI. There are some good examples of utilization review and some very poor ones. It is difficult to determine. A lot depends on the characteristics of the provider. As he pointed out, who you have on the utilization review committee, what the commitment of the board is.

STAFF. How would you rate it?

Mr. TRESNOWSKI. I would say there is a range, there is a wide range with the bulk of them being in the category of fair.

STAFF. What is it that makes one better than another?

Mr. TRESNOWSKI. That is a good question. There are no real clear measures of performance in this regard unless one wants to seek perfection and clear administration in accord with the letter of the law and regulations. I think if one wants to do that, we would find few hospitals meeting the criteria; that is, complete compliance with the letter of the law.

Our criteria is, "Is there a commitment on the part of the utilization committee to do the job rather than to meet just the form of the statute and regulations and are they substantively going about their work of effectively following the regulations?"

Most of them are in the "fair" category in that regard because most are committed to the proposition.

STAFF. Dr. Freedman, do you want to add anything?

Dr. FREEDMAN. I would say we have hospitals with short lengths of stay with poor committees and hospitals with long lengths of stay with good committees. This is a most difficult evaluation to make.

STAFF. Do you regularly get data from each Blue Cross intermediary or subcontractor concerning claim denial rates in each plan and the durations of hospital or ECF stays by diagnoses and treatment?

Mr. TRESNOWSKI. On the first question, claim denial rates, we do get such data.

In terms of lengths of stay by diagnosis, we do not get data on those. We had an admonition from SSA not to accumulate that data. This was to be prepared nationally and transmitted.

STAFF. Have they transmitted that information to you?

Mr. TRESNOWSKI. Not as yet.

STAFF. Do you think the data would be helpful to you in making comparative studies on utilization?

Mr. TRESNOWSKI. Data is a fundamental aspect of utilization. You have to examine the performance.

STAFF. In your relations with the Social Security Administration, do you experience any difficulty in flow of information back and forth? Do you find that the flow of information is smooth and adequate? Are you getting the sort of information and regulations you can administer? Do you see any ways you can improve the flow of information?

Mr. TRESNOWSKI. Our relation with the SSA is a good one. Our communications are quite open. We communicate quite actively back and forth on program policy. I think one can characterized our relationship is that we have learned to agree and disagree with a certain amount of sophistication.

STAFF. Do you ever think about that question, Dr. Freedman?

Dr. FREEDMAN. One of the staff members described it as constructively abrasive. I thought it was a wonderful description.

STAFF. Was that "constructively abrasive?"

Dr. FREEDMAN. I think that is the most desirable kind of relationship you can have.

STAFF. That is fine. I think that is the kind we do have. We have some more questions of AHS. You noted that New York State requires approval of health facilities construction by the local plumbing council and then by the State planning council.

Do you think that such mandatory planning has proved valuable in preventing unnecessary construction and expansion of health facilities?

Dr. FREEDMAN. There is no question. It has done such things as control a chain operation. It has effected such things as unnecessary construction, or badly planned rennovation. It has had a tremendous impact, yes.

STAFF. Do you believe that mandatory planning in all States by qualified agencies would assist in moderating the rise in hospital and extended care costs?

Dr. FREEDMAN. It is long-range planning and one does not garner the benefits of long-range planning and construction planning and renovation planning in a few years.

To go any other way would be madness. If we want to solve the problem in the next 10 or 20 years, this is the only correction I can see.

STAFF. In the staff report to the committee, the staff recommended that planning agencies be broadly representative of all providers of health care services, and not dominated by any single one provider, in order to avoid emphasizing one type of care to the possible exclusion of less costly alternatives.

What is your feeling about that?

Dr. FREEDMAN. I feel that, but I think it also must be broadly representative of the community. Our planning councils are.

STAFF. Subject to the conditions which I believe Senator Miller indicated earlier as to qualification?

Dr. FREEDMAN. Yes. In other words, the beneficiaries, the subscribers are represented, industry is represented, unions are represented, providers, or all kinds of providers are represented. It is a broadly based organization.

STAFF. With respect to your uniform financial and statistical report forms, presumably they can be used nationally?

Dr. FREEDMAN. Sir, I am not qualified to answer the question because I am not a specialist in reimbursement. I would defer.

STAFF. Do those uniform cost reports solve any of the problems in cost finding apart from the duplicative submission of data?

Dr. FREEDMAN. Yes. They are so organized they can be easily computerized and easily analyzed in a uniform method. It gives you the input from which to make an excellent judgment.

STAFF. Has BCA evaluated your uniform financial statistical reporting procedures and forms?

Mr. TRESNOWSKI. We have. It parallels much of what has been developed under the uniform standards for the medicare program. I think there are some significant variations in it. We have a uniform system under medicare. Whether it is the best one is a question, but there is no reason that one can't go with the uniform.

STAFF. It is used, as such, for Blue Cross and medicare and medicaid?

Mr. TRESNOWSKI. That is something before us at the moment. One of the problems with the uniformity in cost reporting has to do with the character of benefits being administered and also principles of allowable costs involved.

If there is a distinction between the two programs, then you have a different form of reporting. If you can come to agreement on what should be paid for, then you have an opportunity for uniform reporting.

STAFF. This is a question for Dr. Freedman and/or BCA: What proportion of your medicare reimbursement to hospitals would you estimate is attributable to cost finding expenses and other clerical expense beyond that ordinarily incurred by hospitals? That is, those costs which are peculiar to medicare?

Dr. FREEDMAN. I have not the ability to make judgment on it. If you wish, we will make such an estimate and give it to you. Mr. Ingraham is a specialist in this field and I would relay the question to him.

STAFF. We would appreciate that.

Dr. FREEDMAN. May I make sure that we have the question. You are interested in the additional cost, if any, for the provider and any additional cost, if any, to the intermediary.

STAFF. Well, we have the intermediary cost data. It is simply in terms of the providers overall costs, what proportion of the costs consist of unique administrative cost finding expense?

Dr. FREEDMAN. We shall be glad to supply it.

(Information supplied follows:)

GREATER NEW YORK'S BLUE CROSS,
New York, N.Y., April 27, 1970.

Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR SIR: With respect to your inquiry concerning the expenses of cost finding and clerical functions incidental to the Medicare program, I have some very mixed emotions. As to cost finding, there is little doubt that the accumulation of the statistical data necessary to cost finding involves an expense particularly as the size of the hospital grows. But as the size of the hospital grows, the expense becomes less and less material to the point where, in terms of reimbursement, it becomes measured at the level of a penny or two per patient day, if that much.

In the smaller institution, cost finding appears to be pretty much a waste of time. Most hospitals of 100 beds or less provide two basic services—inpatient services and emergency ambulatory services. It is a comparatively simple problem in cost analysis to estimate the costs of the emergency department and subtract them from the known total costs of the institution leaving, by exception, the cost of the inpatient service. The thought of doing stepdown cost distributions in a two function hospital is ludicrous on the face of it.

Nevertheless, cost finding in a multi-function institution is not only a must for reimbursement purposes but is also a must for hospital management purposes. For the life of me, I fail to understand how the administrator of a multi-function institution could make intelligent decisions without knowing his costs.

Incidentally, you know that we have established a computer program which does the tedious arithmetic involved in cost allocations based on the statistical information that the institutions have given to us. The cost of such computer application is quite small and takes the sting out of the actual work of preparing the annual financial report.

As to clerical expense, my best guess is that one Medicare billing clerk would be needed for approximately every 200 beds in the institution. This is somewhat an off the top of the head kind of guess but should not be too far out of line. Incidentally, it closely approximates a requirement for Blue Cross billing clerks.

I hope that the enclosed material and information is along the lines that you need. If not, please do not hesitate to get in touch with me and we will see that you get whatever it is that you need.

Sincerely,

JAMES INGRAM.

STAFF. Now, you discussed prospective reimbursement recently, as has BCA, and outlined some of the advantages. Does it have any drawbacks and what are they?

Dr. FREEDMAN. I will give you what is quoted as the outstanding difficulty by the providers. In an area of union negotiations, midyear, a prospective rate established based on history of a past year causes difficult in reflecting the union's settlement or the potential of the union's settlement and its offshoots in even the nonunionized hospitals.

This may require periodic interim adjustments during the year based on massive union settlements and even unionized and nonunion-

ized hospitals. I think this is one of the main characteristics of the difficulty.

Mr. SIBERY. I would add, sir, that if the risk-taking on the part of the provider is really going to be meaningful, then certainly the prospective rate has to be one that is very close to what you can predict they will incur in the way of experience.

We feel that probably the greatest disadvantage to the prospective rate going beyond just a labor component, would be that in order to avoid reviews periodically during the period of time, that there would be a tendency to build in a factor, a contingency factor or something, in order to give them some anticipated area of flexibility.

Risk-taking implies that you do a good job of planning, which means setting goals, translating those into objectives, translating those objectives into resource requirements budgeting and then setting a prospective rate that is realistic.

This will require an evolution, but if we go to the prospective route, I think we have to avoid the tendency that many are pushing for to having a contingency in there that will not require a reevaluation to determine whether or not the risk was unreasonable that they were asked to take.

STAFF. Just one more rather basic question. There has been talk of underwriting in medicare in both parts "A" and "B" and also for medicaid. If Blue Cross were to underwrite, would there have to be a substantial risk factor because of the high risk nature of the population involved?

Mr. SIBERY. Certainly, you have to have your risks well identified in order to make reasonable actuarial projections and the risks involve the number of people involved and what you reasonably anticipate they might use during a given period of time.

I think medicare would provide a much more difficult problem for us in one sense of the word, in trying to make accurate actuarial projections as compared with medicaid, but depending upon the Commissioner attitudes in the various States, we feel with our long experience under the Federal employee benefit programs and other programs, there can be a means devised which would involve underwriting and risk, perhaps in combination with other techniques.

The point I was trying to make earlier, and I would want to reemphasize it here, is that we feel it is worthy of careful exploration and we use our efforts to explore it at great depth.

STAFF. There have been suggestions that supervisory physicians in teaching hospitals should be reimbursed only under part (A) of the program—the part that you administer—and we would like to ask you if you see any problems, if that were to come about?

Mr. TRESNOWSKI. We made a recommendation in the testimony. We did not recommend it become a part (A) benefit but stay as "B" funded benefit, but that the supervising physician in the institution where an arrangement exists be afforded opportunity to combine billing.

This would place the administrative responsibility on the (A) and (B) area. I think we could make a trust fund adjustment at the end of the year. That was our thought.

STAFF. Very simply, in the case of a full-time salaried staff member who has been billing on a fee for service basis for institutional ward

patients, the staff recommendation was essentially no payment of fee for service, but that payment be made as a hospital cost only. That is where the teaching physician is reimbursed for administrative, teaching, and patient care functions, it is too difficult to separate those items out because it varies from minimal to extensive, patient by patient, and therefore pick his compensation up as hospital cost only.

Mr. TRESNOWSKI. You accomplish the same thing with our recommendation. It requires that the total amount of payment out of (A) or (B) be related to his compensation so you get to the same end without disturbing consideration of trust funds.

STAFF. Dr. Freedman, do you have any suggestions on the teaching physician problem?

Dr. FREEDMAN. We have built into our formula a netting out of earned income under any system of practice against the salary paid under any arrangement.

STAFF. Doctor, doesn't it work like so: if the salary is $40,000 a year for the full-time physician and he generates $200,000 in fees, you offset $40,000 against the $200,000?

Dr. FREEDMAN. The principle we were following was we did not want to pay for it twice, we thought it was the greatest problem. The fact that he rendered $200,000 worth of services may be justified and rejustified. However, we could not pay for it twice, therefore we netted it out. This was what we were trying to avoid.

STAFF. Thank you, gentlemen, for the cooperation you have given us today and pursuant to the chairman's direction the committee is in recess until 2 o'clock.

(Whereupon, at 12:25 p.m. the committee recessed until 2 the same day.)

AFTERNOON SESSION

Senator RIBICOFF. The committee is in order.

Our first witness will be Mr. Robert Thomas, accompanied by Fred Rothenberg of Blue Cross, southern California.

STATEMENT OF ROBERT J. THOMAS, VICE PRESIDENT, GOVERNMENT AFFAIRS, BLUE CROSS OF SOUTHERN CALIFORNIA; ACCOMPANIED BY FRED ROTHENBERG, BLUE CROSS OF SOUTHERN CALIFORNIA

Mr. THOMAS. Mr. Chairman and members of the committee, I am Robert J. Thomas, vice president of Government affairs of Blue Cross of Southern California and with me is Mr. Fred Rothenberg, manager of health services reimbursement, to assist in answering your questions.

I have already prepared a report and submitted it to your committee for the record and I would like, with your permission, to make a very short summary statement of that report.

Senator LONG. That is fine. Your regular statement will go in the record and you may proceed and give your summary statement, sir.

Mr. THOMAS. Thank you, Mr. Chairman.

Blue Cross of Southern California is one of the largest Blue Cross plans in the Nation and also one of the largest intermediaries for both medicare and medicaid and shares the concern of your committee in rising health care costs.

Because of this concern, we are very actively working with hospitals and other institutions in southern California experimenting with new approaches in the providing of health services. Our involvement is in three major areas.

More efficient utilization review is one. Alternate methods of delivering health care services is another, and the third is incentive reimbursement for efficiency of operation.

In the area of utilization review, working cooperatively with the Social Security Administration, we are presently conducting a pilot project in California's Riverside and Santa Barbara Counties where the medical societies of those counties have established utilization review committees to review all of the bills of all of the extended-care facilities in those counties.

The payment for the committees' services and also the review of the committees' activities are carried on by Blue Cross as contractor and so there is no fiscal relationship between the providers and the committees.

We believe this gives a more uniform and more objective review of ECF claims. Los Angeles County Medical Association is presently discussing with the Social Security Administration the feasibility of extending this pilot project to include Los Angeles County.

Under Medi-Cal, which is California's medicaid, we are developing a coordinated utilization review activity with Blue Cross of Northern California and California Blue Shield, where we are establishing computer profiles of providers, doctors, and beneficiaries, too, so that we will be able to compare and develop ratios and norms on a statewide basis, both by area and type of provider.

We think this will give a great deal more uniformity and flexibility in determining patterns of care throughout the State and pinpointing areas of abuse.

In the area of new methods of delivery of health care, we have recently reached agreement for a joint prepayment program with Ross-Loos, a 50-year-old medical group in the Los Angeles area. Under this agreement, Blue Cross will provide hospital benefits and Ross-Loos will provide comprehensive doctor and professional benefits.

We also have an agreement with a large dental group to establish a prepaid group practice dental plan in the Los Angeles area. We have also been involved in discussing an alternative plan for several months with the University of California at Los Angeles.

Senator Ribicoff. Pardon, these will involve people over 65?

Mr. Thomas. People of all age groups, Senator.

Senator Ribicoff. All age groups. Do you get permission of those over 65 in medicare to participate in this?

Mr. Thomas. What we are trying to develop here is something that will apply to the whole community including title 18 and 19 bene-

ficiaries, as these programs get far enough along. For example, the UCLA project expects to be underway in the next 2 or 3 months.

Senator Ribicoff. None of these plans are operating at the present time?

Mr. Thomas. This is correct. Many of them are nearing completion and all of them are under very intensive study.

This one at UCLA is a little different from the others in that it is a direct service medical care program, initially involving the staff and faculty of the University of California at Los Angeles, and later being expanded to include the community around the university with the hospital rendering hospital care and medical and dental schools giving professional service.

We are working on this same kind of group practice activity throughout the southern California area, actually, first in conjunction with the Pacific Hospital of Long Beach, with Los Angeles County's Harbor General Hospital, the University of Southern California and Clinic in Santa Barbara and almost all of them embrace the concept of entire communitywide service including titles 18 and 19.

We feel these are indicative of really meaningful experimentation in alternate methods of delivery of health care.

Now, as far as reimbursement is concerned, we have already begun a sophisticated incentive plan in southern California, and actually our plan is two plans. One is a pilot project involving 26 hospitals where medicare and Medi-Cal and Blue Cross patient days are involved.

The other is what we call an interim plan because it involves only Blue Cross days, but applies to some 200-odd other hospitals contracting with Blue Cross. In both of the plans the total labor costs involved in patient care are included and then as the plan develops we intend to include all of the other operating costs of the hospital.

This project is being administered for Blue Cross by the Commission for Administrative Service in Hospitals which we call CASH. CASH is an organization with a staff of hospital oriented industrial engineers and its purpose is to help hospitals get more productivity from their employees by using management techniques which have been successfully used in industry.

That is why we asked CASH to help us develop a workable incentive reimbursement program. Blue Cross of Southern California, the W. K. Kellogg Foundation, and two local hospital associations have put up money to finance an 18-month pilot project for this program, but to make it meaningful we needed the medicare and Medi-Cal patient days. Social Security Administration has approved participation of medicare in the project and has even offered to finance the pilot program for an additional 2 years if needed in order to get meaningful data. The State of California has also approved Medi-Cal program participation.

So, our project is now underway and its objective is to set standards of performance in hospital operation and to measure the improvement or lack of improvement by those standards.

The hospital would then share with the third party payors, the Federal Government and State government and Blue Cross, any costs savings between 2 years of operation, the current year and a previous year, which becomes the base year, and against which the evaluation is made.

Any so-called loss under this program, meaning a failure to achieve a costs savings, would be deducted from any future incentive reimbursement payments.

This program as we have developed it can function equally well under either prospective or retrospective reimbursement and in about 6 months we will have a pretty good idea of its functioning. We will of course, keep SSA up to date as the whole program progresses.

One final comment, if I may, Mr. Chairman, and that is that incentive reimbursement, utilization review and new methods of delivering health care are not solely exercises in hospital economy. They also concern quality of care and improvement in services and certainly this is something we all want, not only for our medicare and medicaid beneficiaries but for all of our citizens.

I hope my brief comments here indicate to you that Blue Cross of Southern California not only shares your committee's concern for the rising health care costs, but is attempting to do something constructive about them.

Senator Williams. I noticed you refer to Blue Cross of Southern California. Do you just operate in the southern part of the State or statewide?

Mr. Thomas. Yes, Senator; we operate in the 13 southern counties of the State. This constitutes approximately 60 percent of the population of the State of California.

Senator Williams. That is the only area in which your organization operates?

Mr. Thomas. Yes, sir.

Senator Williams. Did you figure you would make money on the handling of medicare and medical programs?

Mr. Thomas. We don't actually make money per se, but we do receive many benefits from participating in the program. For example, ours is a very large area, I would estimate somewhere around 40,000 or 50,000 square miles. Los Angeles County alone has more than 4,000 square miles and our field people have to travel a great distance. When one of our field people enter a hospital or ECF now, one of our nurses doing utilization review can review claims for medicare, Medi-Cal, and Blue Cross, so each program is really experiencing only a third of the cost of the visit.

The same thing is true of our reimbursement program and when contract auditors go into a facility, they audit all three so we benefit by participating with the Government in this activity and we feel the Government also benefits by sharing the cost.

Senator Williams. I agree with those conclusions and that is what we had in mind when it was accepted. The reason I asked the question

was because I was surprised at the answers we got yesterday from some of the participants in the program who felt there were no economic benefits to bring a carrier or intermediary and I was a little surprised of medicare being accepted by them just as a charitable operation.

But you say it is of mutual benefit to the Government and you.

Now, the Social Security Administration, in its last contract performance review of the operation of your company, made the overall evaluation, and I am quoting from their report:

In view of the serious problems noted in this report, the plan's overall medicare operations must be characterized as generally unsatisfactory. It is significantly deficient in several areas, workload statistics, level of care determinations, quality control, documentation for providing patient reimbursements, and audit and financial controls.

It is disturbing to note gross and fundamental deficiencies continuing after 3 years of experience in the medicare program.

Do you agree with those conclusions and, if so, have you remedied any of these defects?

Mr. Thomas. Senator Williams, that performance review was done about a year ago. It was in April 1969, I believe, and following that there has been a detailed followup review of our progress by the regional office of BHI and, if I may, I would like to read one short paragraph in that followup report,

At the time of the performance review, the plan was still somewhat in stages of transition, recently having undergone a major reorganization. On July 1, the full-time medicare coordinator was hired and a month subsequent thereto has reflected a period of much greater stability in terms of the medicare operation.

A lot of hard work on the part of the new medicare coordinator, working closely with the vice president in charge of Government affairs and other segments having to do with the medicare program, has resulted in a considerably improved all-around situation in the plan.

Senator Williams. What was the date?

Mr. Thomas. That letter was dated January 6, 1970.

Senator Williams. That was by the Social Security Administration?

Mr. Thomas. Yes.

Senator Williams. That was going to be the next question, but I am glad to get that report. In this same contract review, they stated:

The plan has never denied any home health agency bill. A reviewer came to examine a number of home health agency bills which appeared to be questionable in terms of medical necessity but which were not developed.

What was your response to that finding?

Mr. Thomas. During the last 8 months, our field people, and by this I mean our 16 utilization review analysts, all nurses who are in the field, working with our 18 registered nurses evaluating claims within our organization, have had a significant number of home health agencies on a 100-percent claims review, asking for the medical record with every claim that is processed.

We are still carrying some on 100 percent review. We have rejected a great many claims during the past few months, including 2,116

during 1969. We feel that our review is stiff, but it is equitable. We do not have the agreement of the home health agencies in our area on this and some of their complaints may have reached your ears. But as far as numbers of cases handled is concerned, well, during the last 3 months for example, in home health claims alone, we have returned or have under investigation 26.5 percent of the claims that have been submitted to us out of 21,544 claims. These are our figures and I will be glad to submit the report that I am quoting from to the committee, for the record, if I may.

(The material referred to follows:)

EXHIBIT NO. 1—BLUE CROSS OF SOUTHERN CALIFORNIA, BILL PROCESSING EXPERIENCE DURING CALANDER 1969 AND JAN. 1 TO MAR. 31, 1970

	Total	Inpatient	Outpatient	ECF	HH	Other
Bills received:						
1969	878,602	334,544	340,823	94,531	90,653	18,051
Jan. 1 to Mar. 31, 1970	210,052	84,427	77,377	21,765	21,544	4,939
Bills approved for payment:						
1969	692,778	302,785	228,207	64,630	83,167	13,989
Jan. 1, to Mar. 31, 1970	167,064	77,293	57,273	12,557	15,811	4,130
Bills rejected or denied:						
1969	30,197	2,371	16,172	6,396	2,116	3,142
Jan. 1, to Mar. 31, 1970	5,996	680	1,129	3,784	331	72
Bills returned and/or investigated:						
1969	77,976	26,989	27,058	14,071	8,325	1,533
Jan. 1, to Mar. 31, 1970	22,945	7,801	5,052	4,037	5,724	331

Mr. THOMAS. For the first 3 months of 1970, out of 21,544 claims, there are: 5,724 that are under active review; 331 of them have been completely denied; and, the others are awaiting medical evaluation. If our trend in the last few months continues a high percent of these unfortunately will have to be denied.

Senator WILLIAMS. The same review team states: "The plan has no procedure for detection of fraudulent claims."

Was that true and, if so, what have you done to correct that situation?

Mr. THOMAS. Well, a fraudulent claim is a difficult claim to evaluate at the time of claims review in any event. Fraud would usually be determined at the time of financial audit when the claim can be compared against the records of the facility to determine whether or not the charge slips tie back into the nurse's notes and the doctor's orders and so on.

We have not done much in the way of detection of fraud at the time of claims processing, because there is not enough information on the claim form to perform that review.

Our's is, of course, a retrospective type of reimbursement with cost of settlement at the end of the fiscal period and we anticipate that any incorrect procedures not at arm's length or not properly rendered or fraudulent will come to light at that time.

Senator WILLIAMS. In that connection, in June 1969, the Bureau of Health Insurance conducted a program validation inquiry in six extended care facilities which you serve as an intermediary, and they

found substantial deficiencies and what appeared to be abuse and even fraud.

The auditors attributed responsibility for a good part of those problems to inadequate activity on the part of your organization. Would you care to comment on that?

Mr. THOMAS. As far as the individual cases are concerned, each of these facilities has had extensive counseling since that time. One no longer receives any medicare patients. The claims in question have had the money recouped and our subsequent reports on followup visits to these facilities which indicate that the other five are operating in a satisfactory manner.

Senator WILLIAMS. The General Accounting Office reported to us that many extended care facilities for which you were intermediary had terminated participation in medicare. They indicated excessive delay on your part in identifying such facilities and in making final settlement.

In fact, they noted that 28 of those terminated extended care facilities which re-entered medicare under new ownership had current financing payments of $327,000 outstanding to the old owners even though current financing had been granted to new owners.

Now, exactly what are you doing today to identify and settle such terminated providers?

Mr. THOMAS. May I ask Mr. Rothenberg to respond?

Senator WILLIAMS. Exactly how much of that money has been recovered?

Mr. ROTHENBERG. I am not sure I have the listing of the $327,000 that you are quoting from. If I could go to specific facilities that you are referring to, perhaps I could respond. I don't know if I have the information here.

Senator WILLIAMS. We will have the list furnished for you by the GAO from their report.

Mr. ROTHENBERG. There were facilities which you did query us on insofar as current financing balances outstanding as of the time of termination of the program. All of those facilities have refunded their current financing, so if those are the same facilities, we are talking about, we may have a time cutoff problem, but I will know better after we have a listing.

Senator WILLIAMS. Will you furnish for the record the facilities to which you refer and at the same time we will have the staff give you the record?

Mr. ROTHENBERG. Yes, I have those here. I did check to see specifically if those facilities had refunded the payments and in every instance they had.

Senator WILLIAMS. Furnish it for the record.

Mr. ROTHENBERG. I will be happy to.

(The information referred to follows:)

EXHIBIT NO. 2.—HOSPITAL SERVICES, SOUTHERN CALIFORNIA RESPONSES MADE TO SSA CONCERNING RECOVERIES OF CURRENT FINANCING

Provider No.	Provider name	Period involved	Not recovered or assumed	Comments
05-5871	Villa Contenta	Jan. 1, 1967, to June 2, 1967	0	Balance of $10,170 was outstanding but was recouped from the provider and the new intermediary.
05-5880	Arroyo Grande Community Hospital.	Feb. 8, 1968, to Apr. 1, 1968	0	
05-5608	Centinella Park Convalescent Hospital.	Feb 2, 1967, to Nov. 9, 1967	0	
05-5909	Century Plaza Convalescent.	Mar. 27, 1968, to June 6, 1968	0	
05-5642	Dalewood Rehabilitation	Jan. 31, 1967, to Dec. 1, 1967	0	
05-5160	Flora Terrace	Jan. 1, 1967, to Sept. 1, 1967	0	$42,720 outstanding was assumed by new owner.
05-5589	La Verne Convalescent Hospital.	Jan. 27, 1967, to Apr. 17, 1968	0	Balance of $5,560 outstanding at the time of ownership change assumed by new owner.
05-0114	Sherman Oaks	July 1, 1966, to Nov. 8, 1968	0	Balance of $54,650 outstanding at the time of ownership change assumed by new owner.
05-0219	Studebaker	July 1, 1966, to Nov. 12, 1968	0	Balance of $35,020 outstanding at time of ownership change assumed by new owner.
05-0378	Sun Valley	July 1, 1966, to Sept. 1, 1967	0	
05-0479	Oak Park	July 1, 1966, to June 1, 1967	0	$7,290 outstanding at the time of ownership change recouped through collection.
05-0506	Sierra Vista	Sept. 19, 1966, to Sept. 23, 1968.	0	$41,580 outstanding at time of ownership change assumed by new owner.
05-0514	Lakeview	Jan. 5, 1967, to Jan. 1, 1968	0	$17,430 balance outstanding at the time of ownership change assumed by new owner.
05-3006	Stonybrook	July 1, 1966, to Jan. 2, 1968	0	
05-5557	Yucaipa Valley	Jan. 1, 1967, to May 1, 1968	0	
05-5082	Maryknoll	Jan. 1, 1967, to June 1, 1968	0	$5,720 balance outstanding at the time of ownership change assumed by new owner.
05-5863	Mountain View	Dec. 7, 1967, to Oct. 1, 1968	0	
05-5906	Rinaldi Convalescent Hospital.	Apr. 2, 1968, to June 12, 1968.	0	
05-5432	Riverside Convalescent	Jan. 1, 1967, to Sept. 1, 1968	$5,620	Balance has not yet been recovered. However, we have attached correspondence of Mar. 31 and Apr. 13, 1970, indicating that the prior owners will pay the amount owed. Previous correspondence had been initiated with this provider on Mar. 24, 1969.
05-5791	Rubin's Briarwood	Mar. 1, 1967, to Aug. 28, 1967.	0	
05-5403	St. Marys Desert	Jan. 1, 1967, to Mar. 1, 1968	0	
05-5123	Santa Fe Convalescent	Jan. 1, 1967, to Mar. 31, 1968	0	$1,840 outstanding at the time of ownership change assumed by new owner.
05-5705	United Rehabilitational	Mar. 8, 1967, to July 28, 1967	0	
05-5287	Valley Palms Convalescent	Jan. 1, 1967, to May 1, 1968	0	$11,740 outstanding at the time of ownership change assumed by new owner.
05-7035	Family Service Association-V.N.A.	July 1, 1966, to Sept. 30, 1967.	0	

PETER M. LEWIS, M.D.,
INTERNAL MEDICINE AND GASTROENTEROLOGY,
Riverside, Calif., April 13, 1970.

M. TAMAO,
Reimbursement Consultant, Health Services Reimbursement Department, Blue Cross of Southern California, Los Angeles, Calif.

DEAR MR. TAMAO: I am in receipt of the letter regarding the Riverside Convalescent Hospital—05-5432—in regard to current financing $5,620.00.

We have contracted with Hospital Reimbursement Consultants to have an accounting of this matter which should now be in process. When an accounting is finished, we will remit according to that accounting.

Respectfully,

PETER M. LEWIS, M.D., *Partner.*

Senator WILLIAMS. There has been substantial testimony over the need to make the extended care facility benefit less complex and more available in order to prevent over utilization of costly hospital bills.

If extended care were more readily available, exactly what should be done to prevent overutilization of the extended care facilities?

Mr. THOMAS. We are dealing at the present time with 356 extended care facilities in our Southern California area and no problem gives us more frustration and more friction with our providers than attempting to determine level of care in accordance with the present guidelines.

Now, originally, when Intermediary Letter 328 first came out, a lot of interpretation was left to the intermediary in carrying out provisions of that assurance of payment program. Our difficulties were manifold at the time and we, for many reasons, could not launch an assurance of payment program in some areas.

Since the issuance of the Intermediary Letter 371, which was more specific as to what constitutes nursing or skilled nursing service and so on, we have found considerable improvements. Our own administration and our own guidelines, which we developed and used internally seemed to meet concurrence and we checked them with the people from the Social Security Administration on several occasions.

So, we think our guidelines are all right but the interpretation on the part of the facilities, the extended care facilities, leaves a great deal to be desired. Employee turnover, fluctuations among the staff, many reasons are there and as long as the program is as indeterminate as it is and as subjective in professional judgment as to what constitutes such care, I think the program is going to continue to have these kinds of difficulties.

Senator WILLIAMS. In general, would you concede that the criticism in the Social Security auditors' report to which I referred was at the time valid?

Mr. THOMAS. Senator Williams, I would have to say first that in no instance did we ever concur completely with the auditors but I believe they were objective in their approach and probably correct in most of their interpretations.

Senator WILLIAMS. There were deficiencies at the time?

Mr. THOMAS. Yes, there were.

Senator WILLIAMS. You feel you have made steps to correct that. What are your plans to see that these deficiencies do not continue in the future?

Mr. THOMAS. Our feeling is, Senator Williams, that we have markedly increased the performance of our whole program, the number of professional people participating in it, the number of visits with our facilities. For example, just since September, our utilization review people have made 132 visits to our 42 home health agencies. These visits are not just walkin, walkout, they are either half a day or full-day visits for counseling and assistance.

I think this type of service which we are rendering develops a rapport and understanding between providers and ourselves which is going to help the operation in the future.

Senator WILLIAMS. As one who was very much disturbed by these reports because of the escallating costs of these programs, I will state

that I am encouraged that at this point you recognize there were deficiencies as well as promising to try to modify and correct them.

It has always been my position that you can't correct a bad situation until you first recognize and admit it is there and face it. Then you can go and find ways to correct it. I am encouraged that you frankly admit the fact of the deficiencies and recognize the need to take corrective steps and I hope that in later reports we will see continuing improvement.

Mr. THOMAS. I hope so too.

Senator RIBICOFF. Mr. Rothenberg, how many medicare and medicade beneficiaries are there in the area covered by your company?

Mr. ROTHENBERG. May I clarify what I am responsible for, for the record?

Senator RIBICOFF. Yes.

Mr. ROTHENBERG. I am only responsible for provider auditing. I do not pay claims or handle beneficiary problems and, therefore, those questions I think Mr. Thomas is more capable of answering.

Senator RIBICOFF. All right, Mr. Thomas?

Mr. THOMAS. Senator Ribicoff, our best estimate is that under medicare in our area, we are serving 1,030,000 beneficiaries and under Medi-Cal, it is approximately 1,440,000 beneficiaries.

Senator RIBICOFF. So, you are responsible to some almost 2½ million people?

Mr. THOMAS. Yes, sir.

Senator RIBICOFF. What were the figures that you received in the fiscal year, rather calendar year 1969?

Mr. THOMAS. Calendar year 1969; I have the budget reports in my briefcase but it was between $4 and $5 million for administrative expenses.

Senator RIBICOFF. So, you received from medicare and Medi-Cal funds of between $4 and $5 million?

Mr. THOMAS. I am sorry, I was quoting medicare reimbursement. The Medi-Cal reimbursement, I don't know if my associate knows, but it would be approximately $3 million for Medi-Cal.

Senator RIBICOFF. So, you are dealing with, or in other words, your fees were something like $7 million for both programs?

Mr. THOMAS. These are our cost statements, yes, sir.

Senator RIBICOFF. Now, $7 million is a pretty good sized pool of money; is it not?

Mr. THOMAS. Yes, sir.

Senator RIBICOFF. Don't you think you should be able to operate effectively and efficiently with $7 million?

Mr. THOMAS. We can operate more efficiently with an increased staff in areas of utilization review and claims processing and we are increasing our staff to accomplish this. This amount does not appear great, recognizing that we have disbursed over $600 million during this past year.

Senator RIBICOFF. Well, you have disbursed how much?

Mr. THOMAS. $600 million.

Senator RIBICOFF. $600 million. So, in other words, there is a grave responsibility upon you, not only for the Government, not only for the funded, the people, but the providers of all of these services, and

yet the report that we have indicates that you have done a very, very bad job, to put it mildly.

The criticisms, the findings, the recommendations of the Social Security Administration indicates that there were no scheduled visits to providers to educate them with the entire problem, no change has been made in the interim rate when the cost report reflects overpayment, there are no written guidelines available to admissible processors, no attempt is made to consider the reasonable necessity of charges or necessity for ancillary services, the intermediary should analyze all charges for ancillary services to determine reasonableness of the necessity for such services.

Provider does not have uniform schedule of charges, and at the Alcott Sanitorium the cost report for fiscal 1967 reflects overpayment of $110,000, and the Birch Bank charges are made under "certain suppliers of linens" and other items which should be included in routine care.

It goes on here and these are very disappointing reports to us. It was our intention, of course, that we were going to take experienced people in this field, insurance companies, and the "Blues" and you were a private institution and the long arm of bureaucracy was not to interfere with the health field and you are going to do it cheaper and better and more efficiently.

Now, we find as a general proposition you and all of the other intermediaries have been doing a very bad job. You were responsible for expenditure of hundreds upon hundreds of millions of dollars and you have been reimbursed for your costs or the services for which you are being paid are beneficial to your organization and I think we have a right, and I mean the people of this country and the Government has a right to expect that you are going to do a good job and do it effectively.

Now, you have had some 3 years of experience and it would seem to me you have had much more, or you have had more than enough time to remedy your basic errors or lack of experience in this field.

Mr. Thomas. Senator, if I may respond briefly.

First, the list of items which you have read was reported almost a year ago and we have already responded to those items.

Senator Ribicoff. I just read them in part.

Mr. Thomas. Yes, sir; those and others on the same list which I also have, have been either corrected or are under study or if we took exception it has been noted, but the predominance of them are under correction at the present time.

We have been working on each item very intensively since we received the report and a review of those activities would not find the same thing today. Also, with two programs of the size of ours, and I say this not apologetically but sincerely, that with over 700 medicare providers and with over 1,200 Medi-Cal providers, there was an educational period for all parties, including ourselves, working with providers, working with Government institutions, organizing ourselves, where we were not nearly as efficient as we wanted to be either.

There have been drastic revisions in our overall administrative organization, its structure and capacity. And I am confident that the reviews which we are presently undergoing will show results far different from those during the period quoted.

Senator RIBICOFF. The summary of the conference, Mr. Rothenberg, between you and the Social Security Administration, indicates on the report that I have, that you were rather indifferent to all of these problems and what had to be done.

Now, to me, the problem is so serious that I do believe that we have a right to expect complete cooperation and concern.

Mr. ROTHENBERG. Senator, when I read that comment in the report, I, too, became indignant, because I did not mean to give that impression in the somewhat brief meeting that was held and at which I was present. I think it is not a matter of indifference at all, but a matter of being thoroughly aware of what our problems are and aware of the corrective actions that need to be taken.

Even at that time, which was rather a new period for myself, I did recognize the problem areas and was concerned and was as concerned as the team which came in to review our performance. Believe me, it was not a matter of being indifferent at all. I was very much concerned then and am much concerned now and do want to do the best job we can.

I think some of the statistics and numbers, if you would like to use those, do indicate an increase in performance, increase in both the numbers and the quality of our performance, and as Mr. Thomas has indicated, our objective now is to do a good job while admitting to certain deficiencies in the past.

Senator RIBICOFF. Would the staff want these gentlemen to remain for further questioning?

No; well, thank you very much.

(Mr. Thomas' prepared statement follows:)

STATEMENT OF ROBERT J. THOMAS, VICE PRESIDENT, GOVERNMENT AFFAIRS, BLUE CROSS OF SOUTHERN CALIFORNIA

Blue Cross of Southern California shares the Senate Finance Committee's concern with today's health care problems. Rising costs and uneven access to quality care have created a crisis.

This is a brief report of how one Blue Cross Plan is responding. It deals with incentives to encourage more efficient, economical hospital operation, utilization of services and new directions in health delivery systems.

INCENTIVE REIMBURSEMENT

Hospital costs in 1963 were low by today's standards. But even then, a steady cost rise was viewed uneasily by health field people. In Southern California, Blue Cross came up with an idea. Why, we asked, couldn't scientific management techniques successfully employed by industry be applied to hospital operation, without sacrificing quality of care?

The idea took form with establishment of the Commission for Administrative Services in Hospitals (CASH). Since that time, 120 hospitals subscribing to CASH services have collectively saved millions of dollars through more efficient operations.

When incentive reimbursement for hospitals began to create interest, Southern California already had a foundation. For CASH, with its system for measuring labor standards in hospitals and a competent staff of hospital-oriented management engineers, stood ready to administer such a program.

In 1967, a study conducted by CASH and financed by Blue Cross, the Hospital Council of Southern California and the Kellogg Foundation, revealed that incentive reimbursement was indeed feasible. But to be significant, all hospital labor costs had to be included in the plan, and eventually total operating expense. And all three major third-party payors must participate . . . the Social Security Administration (Medicare), State of California (Medi-Cal) and Blue Cross.

An 18-month pilot program was developed and financing secured through the three organizations paying for the feasibility study and the United Hospital Association. Presented with the program, the Social Security Administration agreed to Medicare participating, offering to pay for a longer pilot run, if necessary. The State of California followed with approval for Medi-Cal.

Under agreement with SSA, Blue Cross is the contractor. CASH is the subcontractor, acting as plan administrator for Blue Cross.

Twenty-six hospitals comprise the pilot group. They represent all types of ownership, large and small hospitals and are situated in both rural and metropolitan areas.

The program is based on a "fair day's work" concept. CASH has identified and measured time required for a properly trained person to perform every task in each labor center and has established standards data. Using these data, each hospital develops its own standard hours for all labor centers and the total hospital, and its own target of productivity.

Each hospital will share with the third-party payor the cost savings (applied only to labor) calculated between two years—previous and current—of operation. The incentive payment will be figured on the individual hospital's rate of improvement and its own level of productivity. CASH engineers, throughout the year, will give hospital management on-site assistance in improving their performance.

In the meantime, all Blue Cross contracting hospitals in Southern California may participate in an interim plan, involving only Blue Cross patient days.

ALTERNATE HEALTH CARE DELIVERY SYSTEMS

Traditionally, Blue Cross Plans pay service benefits for inpatient hospital care—that is, benefits at no dollar limit within the number of days provided by the member's contract, and at a percentage rate of 100% or 80%.

In Southern California, Blue Cross also offers extensive coverage for physician services and other items of care usually included in major-medical type plans. In addition, dental benefits are available.

In 1969 and 1970, we began experiments with other kinds of health care delivery systems.

Group Medical Practice Plans

Early in March, 1970, we signed a master agreement with Ross-Loos, a long-established group medical practice plan, with headquarters in Los Angeles. This arrangement will offer enrolled and prospective Blue Cross group members a choice between an all-Blue Cross program, and one which includes Ross-Loos services. Under either program, Blue Cross will continue to provide benefits at any Blue Cross contracting hospital, but members who enroll in the joint plan can receive a wide range of fully paid medical services (including physical examinations) at Ross-Loos medical centers, in lieu of the usual fee-for-service payment method.

Group Practice Dental Program

We have reached an agreement with a South Bay dentist who now administers a successful group practice dental program. His plan now serves employees of American Metal Products Company and the International Longshoremen's and Warehousemen's Maritime Association Fund.

This dentist also has a smaller dental facility in Southeast Los Angeles and has established tentative participating agreements with two other dental groups—one in the Crenshaw area, and the other in the San Fernando Valley. The arrangement will make it possible for us to implement a prepaid dental plan with four facilities.

Direct Service Medical Care Plan

Our first attempt to implement a direct service medical care plan should be possible soon. We have arrangements with the University of California at Los Angeles (ULCA) to cover services to the facility and staff of the University for care in the ULCA Hospital and Clinics. The plan is to later make the same services available to the community surrounding the campus—again on a choice basis between an all-Blue Cross program and a Blue Cross/ULCA plan.

The University of Southern California School of Medicine is interested in a similar approach—first a campus-oriented health care plan for USC students and faculity, and later a hospital-based medical group practice plan serving the East Los Angeles Community in cooperation with White Memorial Hospital.

A meeting has been held with the administrator of the Santa Barbara Clinic—an old, established multi-specialty clinic, employing thirty-six full time physicians. We are hopeful that some engagement can be made to cover all services by this medical group.

Hospital-Oriented Group Practice Plan

Two hospitals—Pacific Hospital of Long Beach and Harbor General Hospital have expressed interest in some form of hospital-oriented group practice plan which would serve residents in these areas. Committees are now working on proposals.

UTILIZATION REVIEW

In conjunction with the Social Security Administration, we are conducting pilot utilization review projects in Riverside and Santa Barbara Counties. In both areas, local medical societies have established utilization review committees to review all extending care facility admissions for length of stay, level of care and appropriateness of services.

The necessity of an arrangement of this type is because extended care facilities do not have medical staffs—as do hospitals.

Payment for the committee's services and review of activities are by Blue Cross as contractor—removing any fiscal relationships between the committees and the providers.

The Los Angeles County Medican Association is also exploring with SSA the possibility of extending a similar program to Los Angeles County.

For Medi-Cal (Title XIX), a coordinated utilization review program is being developed by the State's two Blue Cross Plans and California Blue Shield. The first phase will be to gather common data which can be used to develop ratios and norms by locality and type of provider. Individual provider norms can then be matched and analyzed.

Reports generated by this system can be used for utilization review committee education in the provider area, to identify any habitual offenders, and to provide information to the Blue Shield subcontractors presently doing medical and utilization review. These data will also be available to medical societies and foundations involved in peer review work, and to individual utilization review committees.

Senator Ribicoff. Mr. Budds?

STATEMENT OF JOHN J. BUDDS, DIRECTOR, MEDICARE, TRAVELERS INSURANCE CO., HARTFORD, CONN.; ACCOMPANIED BY L. E. CARTER, SECRETARY, GROUP DEPARTMENT; JOHN F. TROY, SECRETARY, GROUP DEPARTMENT; AND JOHN F. ANDERSON, ASSISTANT SECRETARY, CLAIMS DEPARTMENT

Mr. Budds. Mr. Chairman, I am John Budds, director of medicare for Travelers Insurance Co. in Hartford, Conn. I would like to present my associates. On my left, Mr. L. E. Carter, secretary of the Group Department of Travelers; on my right, Mr. John F. Troy, secretary, Group Department; and to his right, Mr. John F. Anderson, assistant secretary, Claims Department.

The Travelers Insurance Co. has been extensively involved in both part A and part B of medicare as an intermediary and carrier since the inception of the program. We are pleased, therefore, to have been invited to appear before members of the Senate Finance Committee to present a statement of our impressions and to offer recommendations for possible improvement in the administration of part A of title XVIII.

There are, of course, many complex areas with respect to benefits and administration in a program as large as part A of medicare. Therefore, we thought it would be most helpful, in the brief time which ve have been allowed here today, to detail our thoughts with respect

to several specific areas rather than to attempt to treat in a more general fashion the entire scope of the program.

One overall comment must be made as background to any view of medicare. That is, it must be emphasized that medicare became effective and has been in existence during a period of extreme pressures on existing medical services and also during a period of general price inflation. Therefore, as medicare was superimposed on a health care delivery system already overburdened and suffering under inflationary pressures, those pressures were increased.

It is not surprising that in this environment the planning, development, implementation, and operation of a program of the magnitude and complexity of medicare would bring about the need for some revisions in the program in response to developing problem areas. As a carrier and intermediary, the Travelers is continuously reviewing methods to ameliorate difficulties existing in the program. This activity is directed toward bringing about a highly effective and economical operation of the program, as well as to stimulate improvement in the quality and efficiency of our national health care delivery system.

Part A of medicare provides benefits for almost 20 million people. Under the part A program, hospital benefits, extended care facility benefits, and home health agency benefits are provided. The law established, in effect, a system of levels of care for covered persons. Substantial benefits for the expenses of hospital care are available for illnesses requiring the high concentration of care normally found in a hospital. The extended care facility benefit was designed to provide benefits for those persons not requiring the continuation of confinement in a hospital, but who require continuous skilled services.

The home health agency benefit was established to provide payment for many of the same skilled services that are available in a hospital or extended care facility, with the recognition that these skilled services could be furnished on an intermittent basis in the home to those who do not need continuous skilled care.

We applaud this important concept of levels of care which Congress established in the medicare law. The advantages of medicare beneficiaries moving from hospitals, which have more intensive and correspondingly more costly care, to extended care facilities and ultimately to the home, where less intensive and thus less costly services are available, are indeed obvious when justified by the medical condition of the beneficiary.

However, benefits statistics of the Department of Health, Education, and Welfare establish that 92 percent of part A program benefit expenditures are for hospital service, with only 7 percent for extended care facility services and 1 percent for home health agency services. Based on these statistics against the background of the purposes of the law we have considered methods of facilitating the placement of the beneficiary in the proper level of care and have concluded that a change in present methods of administration would be desirable.

Under present guidelines, timely transfer of a patient from a hospital to an extended care facility is hindered. The present procedures place responsibility in essentially four areas with respect to the admission process of an extended care facility. These are: the utilization review committee of the hospital; the administration of the extended care facility; the fiscal intermediary; and the attending physi-

cian. As established, hospitalization review committees function as a mechanism in determining when a patient should be discharged from the hospital.

Hospitals are inundated with the administrative problems of providing adequate medical documentation, financial accounting and records for medicare and other purposes. In addition, they are looked to to provide medical data that can be reviewed for the purpose of evaluating the need or advisability of transfer of a patient from a hospital to an extended care facility or to the home. This additional responsibility on the hospitals has caused hardship in many instances, particularly as to smaller hospitals who find it understandably difficult to provide a utilization review committee which can perform all of the functions under the law.

Also, hospital utilization review committees require the services of physicians. The availability of a physician's time for the performance of professional medical services has been greatly diminished through the amount of administrative tasks he must otherwise perform for the health care delivery system in general. Since the thrust of this aspect of the law is in the direction of timely transfer of patients, the total impact of the problem is magnified due to the requirement that a physician gave prompt attention to his utilization review committee responsibilities in the hospital.

Extended care facilities are placed in a difficult position at present. The level of care guidelines developed for use by the intermediary in determining the beneficiary's need for "continuous skilled services" in order to qualify for benefits in an extended care facility are sophisticated in their definition and application, requiring the increased employment of professional medical and paramedical staff to analyze each admission and incident care throughout the confinement to resolve questions of requirements for coverage.

The need for review of medical records, physician's orders and the recording of therapeutic progress are inherent in the determination process. The question of whether given care is "necessary" care as required under level of care guidelines too often provokes disagreement among those involved to the detriment of orderly and prompt claim determinations and timely payments. Many extended care facilities have not been able to bring to bear the resources necessary to make determinations which can be relied upon by them in all cases to correspond with the ultimate intermediary determination and, therefore, are reluctant to accept medicare beneficiaries without complete financial security.

The ultimate responsibility for covered care determinations lies with the intermediary. The claim review process, which must be undertaken after the extended care facility admission has occurred and after care has been rendered, has lead to mandatory retroactive determinations that noncovered services have been rendered. This possibility and the resultant financial insecurity to extended care facilities lies at the heart of the problem, especially where no protection is given the facility to recover the cost of care rendered despite sincere efforts to comply with program requirements. This situation also tends to disadvantage the beneficiaries and the families of beneficiaries resulting in program dissatisfaction.

As indicated, the physician, of course, also plays an important role in the admission process, for physician certification of the medical necessity of skilled care services is required for the admission. However, in addition to other reasons mitigating against transfer mentioned above, the undercertainty in this area produces unwillingness on the part of some physicians to recommend the transfer of patients from a hospital to an extended care facility. This results in a paradox since the attending physician is in the best position to evaluate the patient's medical needs. Overall, therefore, it appears to us that the confusion as to the question of covered care has resulted in greater utilization of hospital services, therefore increasing total costs of the part A program.

Thus we recommend the program be changed to provide eligibility for coverage in extended care facilities for a specified limited number of days—not more than 14—based upon the certification by a physician of the medical necessity of skilled care services. This will remove the uncertainty as to whether care will be covered during the initial period of confinement in the lower cost facility and encourage timely transfer. As a result of this proposal also, the activities of the utilization review committee of the extended care facility and the activities of the intermediary will then be able to be concentrated on preventing possible overutilization for the time subsequent to the period of initial approval.

We would like to comment briefly also on another major area, that of provider cost reimbursement. This relates to the existing provider cost reimbursement plan which presently offers limited incentives for more efficient management. The present arrangement provides for final cost adjustment on a retrospective basis which tends to promote excessive delays and also creates extremely high accounting and auditing costs. It would seem appropriate, therefore, to adopt a plan for determining reimbursement rates prospectively.

An adjustable prospective rate could include incentives for management efficiency, incentives to encourage transfer of patients from hospitals to extended care facilities and incentives to encourage expansion and growth of facilities to reduce the recognized shortage of medical facilities. Prospective determination of reimbursement rates will challenge the provider of health services to stay within the limits of the pre-established rate and would thus permit the sharing of any savings resulting from efficient management and effective cost controls.

In closing, several general comments are perhaps in order. In connection with control of utilization of part A services, the Social Security Administration and the intermediary have been utilizing their experience to develop statistical analyses of benefits and expenses under the programs, supplemented by more definitive guidelines. This is resulting in substantial improvement and controls in the areas of both reimbursement and utilization of services.

Another important development is the approval by the Social Security Administration of a part A model computer system. This will be of considerable assistance to intermediaries in improving operational procedures. It will also promote uniformity and will produce a variety of data which will provide valuable management and utilization controls.

Computerization requires a higher degree of centralized operations. The Travelers Insurance Co. has consolidated its part A medicare field

offices serving providers in 14 States from 25 to 12 to complement the model system data processing techniques. Greater administrative efficiency and cost reduction may be expected. The consolidated offices will be in relatively close proximity to beneficiaries and providers. Also, the local offices of the Social Security Administration have rendered significant services in answering questions and giving direction to medicare beneficiaries in conjunction with the intermediaries' field offices.

The Travelers is proud to be a participant in the administration of the medicare program. We look forward to the future believing that much has been achieved from experience. We are confident that increased program efficiency has been gained and will continue to be gained from improvements in systems and techniques and from changes which it is hoped may be brought about by legislation or regulation.

Senator RIBICOFF. Senator Williams.

Senator WILLIAMS. Mr. Budds, I am sure you are familiar with the fact that in previous hearings your company came in for a little criticism as to the loose manner in which the auditors felt that you were administering some phases of this program. I read from one of the auditors' reports, April 1, 1969, that:

> Travelers in Philadelphia, Pa., has an ineffective medicare part A bill review operation as evidenced by (1) payment for noncovered services (the majority of 300 bills reviewed indicated payment was made for noncovered care, at least on the basis of medical and nursing information available); (2) payment for services not medically necessary (there appeared to be indiscriminate use of physical therapy by the providers visited and Travelers paid for such services); (3) failure to deter extended care facilities from, first, requiring deposits (Cobbs Creek attempts to get $100 deposit from all patients for "personal items") and second, getting payment from beneficiaries for covered services when charges for such services are disallowed by the intermediary.

Now what do you have there?

Mr. BUDDS. Senator, in a general way I think that we are aware of these criticisms and have taken broad and positive actions to remedy any deficiency which may have existed in the program overall. As I just mentioned in my testimony, we have reduced the number of our part A offices, we have strengthened our home office and field staff.

Now as regards those particular facilities in the Philadelphia area, we have made medical audits of each. We did identify some overutilization of services. We have made adjustments and have collected these adjusted charges from the providers.

Senator WILLIAMS. I noticed that in commenting on the nursing home, they said:

> Level of Care. Thirty bills paid by Travelers were checked through the medical records of Cobbs Creek and we found 15 obviously noncovered cases in which no payment should have been made. In addition, the majority of the remaining 15 cases were in the gray area where Travelers should not have paid without additional medical information.

The report goes on to state:

> Physical Therapy. It appeared that physical therapy is being provided indiscriminately and in an attempt to justify extended care facility coverage.

Is there any truth to that statement?

Mr. BUDDS. We found some truth. Our medical director personally made a visit to Cobbs Creek Nursing Home. He met with their administrator, their physical therapist, made a review of their bills, in-

cluding those that were questioned, and it was found that there was in effect some $15,500 involved in services that were deemed not covered under the program. The provider has made an adjustment of this amount.

Senator WILLIAMS. The committee, and then again this morning the Blue Cross, expressed its concern over the tremendous growth of chain and conglomerate organizations in the health care field. Do you share that concern?

Mr. BUDDS. Senator, we are not the intermediary for any so-called public national chain so I don't believe we are in a position to answer that question.

Senator WILLIAMS. One of the questions raised was the possibility of self-dealing. Now precisely how do you assure that there is no discriminatory self-dealing between these related oganizations?

Mr. BUDDS. Well, insofar as providers are involved, this is determined through the audit to determine whether or not there are any related organizations involved in connection with rent or purchase of any other services. This is an audit function.

Senator WILLIAMS. Well, mention has been made that you were serving as a member of the board of directors of a nursing home chain while at the same time you were Travelers' director of medicare operations. Now do you feel that there was a conflict of interest relationship in that deal?

Mr. BUDDS. No, I don't, sir.

Senator WILLIAMS. Did you continue it and do you still continue it?

Mr. BUDDS. No, I did not. I resigned. There was some criticism of my involvement, and as long as there was I resigned because I had no strong personal interests or involvement in the chain.

Senator WILLIAMS. And you would see no conflict of interest in the managers or whoever is administering the medicare operations or medicaid operations of one of these carriers being on the boards of directors of the organizations benefiting from those programs?

Mr. BUDDS. None of the homes involved in that chain were involved in medicare.

Senator WILLIAMS. On medicaid?

Mr. BUDDS. I don't know about medicaid because we were not involved in medicaid. But I was told when I was invited to serve on that board this this chain was going to involve itself only in long-term care and that they were not going to be involved in medicare.

Senator WILLIAMS. It was my understanding that they applied for medicare.

Mr. BUDDS. Not at the time I was on the board. I think after I resigned from the board they did purchase some homes that already had involvement in the medicare program.

Senator WILLIAMS. But the prospectus for the chain came out before you resigned, and was not your name carried as a member of the board in the prospectus and in that prospectus did they not also refer to the profit advantage that might be derived as a result of the medicare and medicaid programs?

Mr. BUDDS. That is right. I accepted appointment on the board before the prospectus.

Senator WILLIAMS. So your name was used on that basis at the time?

Mr. BUDDS. Yes.

Senator WILLIAMS. Do you think that was correct and would you recommend it again?

Mr. BUDDS. No, I do not. I did not think it was going to be used in this context. As I said, I had no great personal interest or involvement. I was invited to serve by a man with whom I had worked by virtue of the fact he was an officer of the American Nursing Home Association in the State and the Massachusetts Federation of Nursing Homes, and he was very anxious to have someone from the insurance industry on it.

Senator WILLIAMS. I can see why he would be. I commend you for taking steps to correct it. I am a little bit concerned with the fact that in retrospect you see nothing wrong with it so that you would do it again.

Mr. BUDDS. No, I would not, sir. I did not have all the facts when I accepted this appointment. In fact, I was able to attend only one meeting of the board.

Senator WILLIAMS. How much stock interest were you supposed to have?

Mr. BUDDS. Just some qualifying shares which I disposed of when I resigned.

Senator RIBICOFF. We will recess for 10 minutes. There is a vote going on in the Senate now.

(Whereupon, a short recess was taken.)

Senator RIBICOFF. The committee will be in order.

There are a few questions I have of Mr. Budds awaiting Senator Williams' return.

How many States does Travelers have under their jurisdiction?

Mr. BUDDS. We are in 14 States.

Senator RIBICOFF. Fourteen States. Do you have the number of medicare or medicaid beneficiaries that come within its jurisdiction in these 14 States?

Mr. BUDDS. No, I do not, Senator. Generally speaking the part B carrier serves the individual beneficiaries. We serve the providers who nominate us in these particular areas.

Senator RIBICOFF. How many social security beneficiaries are covered in the States that you serve? Do you know that?

Mr. BUDDS. I don't have the figure available.

Senator RIBICOFF. You don't. Do you know the amount of reimbursed fees you received in 1969?

Mr. BUDDS. Under part A we received reimbursed administrative expenses of $2,941,000.

Senator RIBICOFF. In part A. You also have part B?

Mr. BUDDS. Yes, sir.

Senator RIBICOFF. What did you receive under part B?

Mr. BUDDS. $2,494,000.

Senator RIBICOFF. $2,494,000.

Mr. BUDDS. Yes.

Senator RIBICOFF. So you do better than $5 million of reimbursement.

Mr. BUDDS. Yes.

Senator RIBICOFF. Do you utilize the experience that you have here and the personnel and other medical programs and health programs that the Travelers have—the computers, the personnel?

Mr. BUDDS. Yes. We utilize our medical department. We have a medical director who serves the medicare program. We do utilize our computer services and other services of the Travelers that are available in the service area.

Senator Ribicoff. Do you figure you make any money on this over $5 you take in?

Mr. Budds. No, sir. We are reimbursed for our costs.

Senator Ribicoff. You have actual costs of reimbursement that must include certain overhead of running the company, isn't that right?

Mr. Budds. Yes.

Senator Ribicoff. The overhead is included in that $5 million?

Mr. Budds. There are certain allowable overhead costs that are included in the reimbursement.

Senator Ribicoff. Do you have any suggestions or any ideas of alternative programs that you would be willing to undertake if you have the opportunity under medicare or medicaid, some different system under part A or part B? Would there be something you would like to try out?

Mr. Budds. Well, I don't have anything specific in mind but we would be very pleased, I think, to participate in any program of experimentation that might help the medicare program.

Senator Ribicoff. But you have no suggestions yourself as to an experimental program?

Mr. Budds. No, sir; except the suggestions that have already been made as to changes in the administration of the program.

Senator Williams. I was discussing the chains and conglomerates. Perhaps you have already noted that, but I read from an HEW report on page 259 of the previous committee hearings last July:

> It is quite apparent that a wide variety of problem areas exist that we have suspected and attempted to cope with in the principles of reimbursement. For example, locking and/or related corporations and owners, owner's compensation, change of ownership which may not be at arms length, and so forth. Common-owned ECF's which raise questions concerning compensation were revealed, such as—

and then they list four of these companies. We will put them in the record. That is on page 259 of this report and they are Wentworth Manor; Ann Vinal; Mildred Alford, New Hampshire; and Linda Richards, New Hampshire.

It states here:

> An analysis determined that the owners are claiming owner's compensation in each facility with no designation of the amount of time devoted. A total of 10 individuals are involved who have claimed about $196,200.

Now what is your opinion? These were facilities that came under your jurisdiction. What do you find on that and what steps did you take to make sure that you were not allowing excessive costs as a result of this?

Mr. Budds. I know of the visitations. I am not well acquainted with each and every one of these cases but visitations were made to these facilities. We have cost records. As you know, audits have been made. Where there were relationships that were improper, the costs would be disallowed. I do not have the specific information here with me but I could make it available to you.

Senator Williams. If you would make it available.

(The material referred to follows:)

THE TRAVELERS,
THE TRAVELERS INSURANCE CO.,
Hartford, Conn., April 27, 1970.

Chief Counsel, Committee on Finance,
U.S. Senate, New Senate Office Building,
Washington, D.C.

DEAR SIR: During the course of my testimony before members of the Senate Finance Committee on April 15, 1970 Senator Williams asked what steps had been taken to make sure excessive charges were not allowed to the four related organizations listed on page 259 of the report of the hearing before the Committee on Finance of the United States Senate on July 1 and 2, 1969, that is, Wentworth Manor, Ann Vinal, Mildred Alford Nursing Home and Linda Richards Nursing Home. I responded to the effect that cost records were reviewed and audits were made and improper costs were disallowed. I indicated I did not have the specific details at hand but would make them available.

We deem the statement in the report of July 1 and 2, 1970 hearings "no effort was made or is contemplated to evaluate an individual's total owner's compensation in the various facilities" to be incorrect. There was, in fact, a reduction of the allowable compensation in each of the four facilities, as indicated on the attached statement. Actually, as a result of the desk reviews, there was a total reduction of $136,570 making the total allowable owner's compensation for reimbursement $59,649 for the four facilities instead of $196,219, the total amount contained in the cost reports originally submitted.

The reference to the fact that the desk review of cost reports should have screened out management fees and/or consultant fees, interest expense and rental expense seems inappropriate since these items were identified in the desk review process and were called to the attention of the auditors for verification and proper adjustment in the audited reports.

I am attaching a statement and a copy of a memorandum, both prepared by Mr. Voris H. Fabik, Reimbursement Administrator, Medicare Administration, Travelers Insurance Company, which presents in detail the audit findings and subsequent adjustments to allowable costs for the four facilities named.

I trust this letter and the attached documents will provide you and the Committee with the desired information. However, if you wish further details please communicate with me.

Sincerely,

JOHN J. BUDDS,
Director, Medicare.

AUDIT FINDINGS AND SUBSEQUENT ADJUSTMENTS TO ALLOWABLE COSTS (OTHER THAN OWNER'S COMPENSATION

(1) Desk Review identified cost reports of Linda Richards (22–5107) Wentworth Manor (22–5108) and Ann Vinal (22–5105) had been prepared using consolidated operating statements instead of operating expenses per provider's records and the adjustment to the provider's "costs" to reflect costs of the related organization. Audit capability was instructed to determine the necessary adjustments to bring the data on the reports to reflect required form presentation per cost report completion instructions. The adjustments were significant in number as they affected the computation of equity capital as well as the allowable costs. General categories of adjustments were:

(a) Rental cost adjusted to cost to related organization.

(b) Interest expense adjusted to allowable expense per Principles of Reimbursement.

(c) Charges to provider for services furnished by related organizations adjusted to costs to the related organization.

(d) Necessary related adjustments to compute equity capital for both provider and assets being leased from related organizations.

(2) Desk Review identified cost report of Mildred Alford (22–5097) was submitted including rental charges and Management fees from related organizations. Audit capability was instructed to adjust such claimed costs to the cost to the related organizations for assets and services furnished provider. Audit adjustments were made.

Audit examination required expansion to assure all related organizations were identified and only costs to related organizations were incorporated in the costs of provider to compute Medicare reimbursement.

ANALYZATION OF OWNER'S COMPENSATION CLAIMED, ADJUSTED FOR INITIAL SETTLEMENT AND ALLOWED BY AUDIT

	Linda Richards 2–5107			Wentworth Manor 22–5108			Ann Vinal N/H 22–5105			Milford Alfred N/H 22–5097			Summary total		
	Claimed	Adjustment for initial settlement [1]	Allowed by audit	Claimed	A justment for initial settlement [1]	Allowed by audit	Claimed	Adjustment for initial settlement [1]	Allowed by audit	Claimed	Adjustment for initial settlement [1]	Allowed by audit	Claimed	Adjustment for initial settlement	Allowed by audit
E. L. Dahlquist [5]	11,858		2,310	13,107		4,100	11,100		2,135				36,065		8,545
H. F. Trube [6]	18,343		8,795				25,000		8,870				43,343		17,665
J. T. Dunn, Sr. [7]	10,758	58.45	1,100		38.47		10,000	61.52	950	15,600	51.14	4,825	36,358		6,975
M. R. Sanesi [8]	10,758	([2])	300		([2])		10,000	([2])	450		([2])		20,758		750
J. J. Anthony [9]				11,507		2,500							11,507		2,500
T. J. Hadge [9]				11,507		2,500							11,507		2,500
R. P. Brainerd [9]				11,507		2,500							11,507		2,500
E. T. Wentworth, M.D. [9 10]				7,514		4,900							7,514		4,900
J. T. Dunn Jr., [11]										12,660		12,660	12,660		12,660
E. S. Dunn [12]										5,000		3,000	5,000		3,000
Total	51,717	([3] 18,562)	12,505	55,142	(17,750)	16,500	56,100	([3] 28,096)	12,405	33,260	([3] 6,648)	20,485	196,219	(71,056)	61,995
Total adjustment to compensation-desk review	[4] −31,757			[4] −46,142			[4] −45,671			[4] −13,000			−136,570		
Total	19,960			9,000			10,429			20,260			59,649		

[1] H.I. costs portion (percent).
[2] Represents estimated percent of medicare costs to total costs per cost report filed (unaudited).
[3] Amount of reduction to medicare reimbursement on initial settlement (2) times (4).
[4] Total owner's compensation disallowed for initial settlement purposes.
[5] Audit determinations based upon 100 percent of time devoted to operations of the 3 homes. Allowable amounts determined on basis of estimated time spent in each facility (assistant administrator).
[6] Audit determinations based upon 100 percent of time devoted to operations of the 2 homes. Time spent equals ½ in each facility (assistant administrator).
[7] Audit determinations based upon 50 percent of time spent in operation of Milford Alfred N/H, 22–5097 and time devoted to Linda Richards, 22–5107 and Ann Vinal, 22–5105 administration through Board of Governors (basis per board meetings attended).
[8] Audit determinations based upon time devoted to Linda Richards, 22–5107 and Ann Vinal, 22–5015 to administration through Board of Governors (basis per board meetings attended).
[9] Audit determinations based upon time devoted to administration through Board of Governors. Wentworth Manor overall administration handled by Board of Governors in lieu of administrator per se.
[10] Audit determinations includes time devoted to operations as medical director in addition to member of Board of Governors.
[11] Audit determinations based upon 100 percent of time devoted to operations as administrator.
[12] Audit determinations based upon 30 percent of time devoted to operations as director of nursing.

Senator WILLIAMS. The point I am making is, do you recognize the danger in these situations which result in excessive charges being made under the medicare program or medicaid programs?

Mr. BUDDS. This is an area which concerns, I think, everybody involved in the program. The intermediary group was meeting with the Social Security Administration last week, and this concern about the involvement of ownership in facilities is one that is very troublesome. We are finding that many of these homes are being sold and we are not aware of it until we go in to make an audit.

Senator WILLIAMS. Well, we find those situations and then we find, as we mentioned earlier, that during that transfer of these homes, sometimes from one corporate structure to another, they merely pyramid the price which results maybe in approved higher depreciation rates through a higher valuation on the home. Do you check that? What steps do you take to make sure that this is just not a method of getting higher reimbursement?

Mr. BUDDS. This is checked out in the audit process to determine that whatever the financial transactions are they must come within the principles of reimbursement and the rules and regulations laid down by the administration and they must follow the concept of reasonableness and concept of a prudent buyer.

Senator WILLIAMS. In these audit reports we found that several times your company has come up for specific criticism because these were not being checked properly or not being enforced. I just wanted to be sure that you recognize this problem and if you were checking it. What steps have you taken to collect these overcharges?

Mr. BUDDS. We recognize it fully, Senator. We have a very definite procedure for collecting overcharges. It is a very well defined procedure, defined through the Bureau of Health Insurance. Where money is owing the program, of course if there are medicare benefits available they are not paid to the provider until the indebtedness is liquidated.

Senator WILLIAMS. But if there are not benefits owing them or if they switch to another method of operation, what steps do you take to make sure you are pursuing it?

Mr. BUDDS. We pursue it fully. There is a procedure to turn it over to the regional office of the Bureau of Health Insurance and we follow through legally from that point on.

Senator WILLIAMS. How many areas do you represent?

Mr. BUDDS. We are in 14 States, sir.

Senator WILLIAMS. Fourteen States. How many were you in when you first started?

Mr. BUDDS. I believe we have been in these 14 States in part A since the beginning of the program.

Senator WILLIAMS. Do you make money out of this operation?

Mr. BUDDS. No, sir.

Senator WILLIAMS. None at all?

Mr. BUDDS. No; it is a cost reimbursement program.

Senator WILLIAMS. It is strictly cost reimbursement?

Mr. BUDDS. Yes, sir.

Senator WILLIAMS. Then again if other arrangements were made to use other intermediaries, you would have no objection at all?

Mr. BUDDS. I do not understand your question, sir.

Senator WILLIAMS. If there is no profit at all for you, any changes that were made, if we wanted to make changes in some of the intermediaries, I assume you would have no objections, you would just be relieved of that patriotic endeavor.

Mr. BUDDS. No, I don't think we are in it entirely for a patriotic reason. I think we do recognize our social responsibility. We are a large writer of health insurance; we write over a billion dollars a year in premiums in our own business, and we are interested in having an involvement with the Federal Government. We are interested in being on the inside of this program, as it were. Our people sit on various committees with the Social Security Administration and it gives us a part of the program that we think is desirable.

Senator WILLIAMS. Frankly, I respect your company as I respect the industry and I respect the profit motive, but I am amazed at the fact that apparently the Government has worked out an arrangement with all the companies coming in anxious to participate in the program where they do not benefit but just from public spirit. I wonder if the Secretary of HEW moved over to the Defense Department, would we find that same sentiment prevailing, or isn't it a fact that there is some profit motive here? I do not quarrel with the fact that there is a profit, but as one who was in private industry I was never ashamed to make money. I do not see why you fellows are doing it for nothing. I just say this, I am a little surprised.

Mr. BUDDS. May I say, Senator, that in the early stages of the program our company strongly recommended an incentive program for intermediaries and carriers.

Senator WILLIAMS. Why would the Government pay an incentive program when there are so many people anxoius to do it for nothing?

Mr. BUDDS. That is probably why we did not get very far with our recommendation.

Senator WILLIAMS. Perhaps that is why we are not getting any better administration, either. Maybe that is the reason you feel there is nothing to it other than just to siphon it out.

There must be some advantage to it but maybe you and I don't understand, and maybe directors in fact do understand better, because, if not, I am going to suggest that some of the other agencies of the Government, who are paying substantially more than they should pay, call on some of you gentlemen to show them how you operate on the level of patriotism where everybody works for nothing and just clamors for the job. I accept it that you are not making any money, but I would assume that you would be glad to get rid of it if the Government felt they could find somebody else who would do it for a little less than nothing and save us a lot of money.

I notice in this HEW report that there was a notation made that all insurance on buildings under construction by this nursing home operation were to be placed with Travelers. Now do you have any interlocking relationships such as where you might serve these extended care facilities for nothing, or the individuals, and then in turn they buy their insurance from you? What do you think of such a relationship?

Mr. BUDDS. We don't have any such relationship, Senator. We who are in the medicare program have no idea of whether or not any of

our facilities carry insurance in our company. There is just no correlation whatsoever.

Senator Williams. You will concede the fact that we want to make sure that there is no interlocking relationship; that there would appear to be a conflict of interest even though it was not so intended?

Mr. Budds. No, we don't make any attempt through our medicare program to assist in the writing of insurance in our regular business.

Senator Williams. Now you served as the intermediary for the Hollis Park Nursing Home and there were what appear to be quite obvious abuses there. It was suggested that as a result of the poor effort made there, the Government was going to sustain a possible loss of $350,000 in overpayments. Now could you tell us why this Hollis Park situation developed and what has been done about it and why you did not detect it prior to the HEW auditor's finding?

Mr. Budds. Well, Senator, this case is in litigation, it has been turned over to the Justice Department. All our records have been made available to them. I don't know whether these will be judged to be overpayments as you have indicated or not. I think it is a matter of a situation now in the courts.

Senator Williams. Since it is in the courts we won't pursue the point, but I notice that HEW in their audit report found it and called it to your attention. Would that indicate a lack of supervision on the part of the company?

Mr. Budds. I think this was an area where at that stage of the program there was not available any pool of data in the area of physical therapy and other ancillary services, it was very difficult to make judgments. I think this had something to do with the situation which developed. Also at that time there was a great deal of pressure for processing of bills so that payments would be made and beneficiaries would not be held up in connection with payments. I think that after this case is adjudicated we can make a better determination as to just what the situation was.

Senator Williams. Do you or does anyone in the company, to your knowledge, have nonmedicare financial transactions or loans, or mortgages with any facilities which you serve as an intermediary?

Mr. Budds. No, sir; we have none.

Senator Williams. You have none. You recognize that such a situation could be an implicit conflict of interest and you would have to avoid it.

Mr. Budds. Yes.

Senator Williams. I have no further questions.

Senator Ribicoff. Just one final question. You mentioned in answer to questions by Senator Williams that at the beginning of the program you recommended an incentive plan. What did you have in mind?

Mr. Budds. Well, some kind of an incentive or profit, if you will, for intermediaries and carriers who might perform effectively. It is a very difficult thing to establish, but I think it was felt by our top management that there should be some reimbursement for the services that we might perform in the medicare program.

Senator Ribicoff. I think as I listen to questions from the committee table here that there would be no reluctance for an incentive provided the incentive would bring more effective, efficient services and lower costs. No one has the objective. I think they are all rather

skeptical that we don't believe that people should be working for nothing. I don't think any of us want anyone to work for nothing.

Would you be for a disincentive for poor service?

Mr. Budds. I think you would have to have some plus and minus factors. I think perhaps something along the lines of the defense contracts with an escalating type clause.

Senator Ribicoff. Evidently you do have an organization of insurance companies involved here.

Mr. Budds. Right.

Senator Ribicoff. Have you ever discussed that?

Mr. Budds. Yes; but the majority of them did not feel the same as the Travelers.

Senator Ribicoff. They didn't. I think it is something worth considering, whether they can arrive at some proposal. It would be interesting for the committee study.

Well, thank you very much, Mr. Budds.

Mr. Robert Stewart, Aetna Life Insurance Co.

STATEMENT OF ROBERT E. STEWART, DIRECTOR OF MEDICARE ADMINISTRATION, AETNA LIFE & CASUALTY; ACCOMPANIED BY JON C. McFATHER, MANAGER, PART A MEDICARE OPERATIONS; JAMES A. DORSCH, WASHINGTON COUNSEL; AND JAMES H. HUNT, DIRECTOR OF GOVERNMENT RELATIONS, GROUP DIVISION

Mr. Stewart. Mr. Chairman, I am Robert E. Stewart, Director of Medicare Administration, Aetna Life & Casualty. With me are Mr. Jon C. McFather, manager of our part A medicare operations; Mr. James A. Dorsch, our Washington counsel; and Mr. James H. Hunt, our new director of Government relations for the group division.

We appreciate the opportunity to appear here today and comment on certain of medicare's problems that face the Congress, the Department of Health, Education, and Welfare, the Social Security Administration and those organizations, such as Aetna Life & Casualty, that have volunteered their services in delivering the program to our elderly citizens. The Aetna has already appeared before the House Committee on Ways and Means and in testimony delivered by Daniel W. Pettengill, vice president, group division, on November 6, 1969, set forth in detail proposals with regard to the broad health care problems currently facing our Nation. Today, however, we have been requested to confine our testimony to the operation of the present medicare program, and part A in particular.

We support the comments and recommendations of the Medicare Administration Committee of the Health Insurance Association of America that were presented in testimony here yesterday. We do not intend to reiterate all of that testimony; however, we would like to focus on two of the recommendations that appear to us most important—a restructuring of the posthospital extended-care benefit and a change in the method for reimbursing health care institutions.

Part A of the medicare program promotes the very desirable concept of progressive patient care; that is, it takes the patient to the hospital for necessary acute inpatient treatment; on to the nursing home for necessary inpatient convalescence that requires continuous

skilled care and, finally, to his home where it provides home health services, when available and necessary. However, this seemingly smooth road of progressive care has an unpaved stretch from which stem many of the problems and concerns with this part of the program.

Under existing provisions of the law, regulations and administrative instructions, medicare benefits are payable for posthospital confinements in nursing homes only if the patient requires continuous skilled services; that is, services which must be furnished by or under the supervision of trained medical personnel. Many patients who can be discharged from hospitals do not require continuous skilled care; however, they do require intermittent skilled, semiskilled or unskilled care. Many of these patients live alone or do not have family capable of caring for them during the convalescent period. If they cannot privately finance their confinement in a nursing home, what happens to them?

This situation places the physician in a difficult position. He cannot ignore the patient's medical welfare. Therefore, since medicare doesn't pay for this type of nursing home care and since the patient is unable to do so, he has few, if any, alternatives to keeping the patient in the high-cost hospital. If the law were changed to eliminate the requirement for continuous skilled nursing home care, physicians would not face this dilemma and should be less reluctant to transfer patients from high-cost hospitals to lower cost nursing homes.

While recognition of lower levels of nursing home care should tend to decrease the amount of hospital benefits paid under the program, there undoubtedly would be utilization of nursing home benefits by those not now eligible. For this reason we agree with the Medicare Administration Committee's recommendation that the number of days of covered nursing home care be reduced.

In addition, we would suggest earlier application of a coinsurance payment for hospital confinement. Our reasoning is as follows: If a patient is transferred to a nursing home, coinsurance payments begin on the 21st day. In the hospital, however, a coinsurance payment is not required until the 61st day. Thus, in the stiuation where the physician can justify proper medical care in either type facility, the patient's financial welfare is better served by his remaining in the hospital until the 61st day. However, if a hospital coinsurance payment commenced on, say, the 21st day of confinement, the patient would be better off financially if he were transferred to the nursing home after the 20th day because he would be eligible for up to 20 additional days of care without a coinsurance payment.

The objection to moving up the hospital coinsurance payment date would be the hardship this may create for those in real need of hospital care in excess of 20 days. For this reason, we would suggest a lower hospital coinsurance payment from the 21st through the 60th day than is now applicable after 60 days. Perhaps a coinsurance payment equal to that required for nursing home care after 20 days would be reasonable for this period of hospital confinement.

A restructuring of the nursing home benefit to provide coverage for more than one level of care and earlier application of a coinsurance payment for hospital confinements will, in our opinion, encourage

more efficient use of these two major type health care institutions. While these changes might not overcome the physician's natural preference for treating his patients in the hospital, they should, when considering his patients' financial situation, reduce his reluctance to utilizing lower cost facilities. These changes should also encourage beneficiaries and their families to ask physicians to use the lower cost nursing home.

The report of your staff cites problems related to the reimbursement of institutions providing medical care. The majority of these problems, we feel, can be alleviated by changing the present retroactive cost reimbursement method to a prospective negotiated rate that would be applicable for a specified period of time. This prospective rate would be based on the institution's past cost experience and would take into consideration reasonable anticipated increases in costs during the prospective period.

Once the rate were set, it would apply to all health care services provided by the institution to medicare beneficiaries during the prospective period. To the extent that an institution could improve its administrative efficiency and provide health care services for something less than the negotiated rate, the savings would represent a tangible and monetary reward for its efforts.

We further recommend that the prospective rate be applicable to all patients served by the institution. We agree with the American Hospital Association's recommendation that medicare should share in the cost of providing all services, including those not generally applicable to the medicare age group. On the other hand, nonmedicare patients should share the cost of all services, including those peculiar to medicare patients.

This approach to reimbursement should also reduce the extremely high administrative costs incurred by intermediaries in conducting annual on-premises audits of institutions' costs. It should also permit better advance fiscal planning on the part of health care institutions.

Various critical comments have been made regarding the administration of the medicare program. No one involved with its administration should wish to deny that mistakes have been made. There are many reasons for these mistakes, not the least of which is the sheer size of the program. Too many things have been required of too few people in too short a time to have, even today, administrative perfection. However, now that a reasonable shakedown period has elapsed and with the benefit of hindsight, solutions to some of the administrative problems are coming into clearer focus. New and better procedures are evolving.

You may be interested to know that during 1969 Aetna presented a plan for computerizing many of the administrative functions required of intermediaries under part A of the medicare program. The Social Security Administration has approved the plan and has authorized us to develop and implement the system. When completed, it will be available for use by other intermediaries and will make possible improved efficiency and uniformity in program administration.

We have also taken the Social Security Administration's part B model system and have adapted it for use in our multistate part B operations.

Implementation of this system has already been completed in one of our field offices and expansion of the system to other offices is scheduled for this year.

While many of medicare's problems are being resolved administratively, other problems will yield only to legislative action. We urge this committee and Congress to act favorably on our recommendations and those of the Medicare Administration Committee.

Mr. Chairman, that concludes our prepared testimony. We will do our best to answer any questions which you may have.

Senator RIBICOFF. Mr. Stewart, may I commend you on the constructive suggestions you have made. This is the type of testimony we have been hoping for, that out of your experience in the field that you would come up with some ideas of how to improve the entire system. I have talked with Senator Williams and you happened to hit on a few points that we had been discussing privately. I want to tell you how pleased I am with your testimony.

Now how many States does Aetna cover?

Mr. STEWART. In part A we serve hospitals, nursing homes, and home health agencies in 10 States, Senator.

Senator RIBICOFF. In part B?

Mr. STEWART. In part B we have six States plus the Island of Guam.

Senator RIBICOFF. Six different States. Are they part of the 10?

Mr. STEWART. No; six different States.

Senator RIBICOFF. So you have 16 States and the Island of Guam that you cover one way or another.

Mr. STEWART. You might say that. In a couple of instances, one instance that I can recall readily, the part A and part B overlap.

Senator RIBICOFF. So you cover about 15 States.

Mr. STEWART. Right.

Senator RIBICOFF. Do you know the number of medicare or medicaid beneficiaries that are allocated in those States or covered in those States?

Mr. STEWART. I don't know the number of medicare beneficiaries in those States where we operate as part A because we are concerned primarily with the hospitals, nursing, homes, et cetera. In our part B States it is roughly a half a million.

Senator RIBICOFF. During 1969 what was the total amount that you received from the Social Security Administration for services that you rendered?

Mr. STEWART. Our final cost proposal for 1969 just recently submitted to the Social Security Administration under part A was $2,470,376. This included roughly $1 million in what we refer to as provided audit costs. Many of these funds were paid to outside national audit firms but the total was as I gave it.

Did you want part B, too, Senator?

Senator RIBICOFF. Yes, sir.

Mr. STEWART. Under part B for the same period our total administrative expenses were $3,202,853.

Senator RIBICOFF. So you receive something like $5,200,000 from the Government for what you do.

Now do you make any profit on this $5 million plus?

Mr. STEWART. Not monetary profit. I am sure that you are aware of the way the law reads. It is a cost basis, not a cost-plus basis.

Senator RIBICOFF. What are the advantages to Aetna in doing this?

Mr. STEWART. Around the time that the medicare law was being passed, those organizations who had experience in the health care field had to make a decision as to whether they wanted to participate in the administration of the program or whether they didn't. There were many unknowns at that time. All we did know was that Aetna, as the largest private health insurer in the United States, should be vitally interested in what this new Federal program was going to do and what effect it would have on our private business.

I guess, as I have told so many of our people that have asked us this same question, we sort of felt that if you want to know what is going on, it is better to be in the room than out in the hall looking through the keyhole. So by participating in the program we are better aware of what is going on, we feel, than if we were not participating. We are aware of the new developments and techniques.

Senator RIBICOFF. Mr. Budds talked about his suggesting at the beginning of this program that there be some incentive payment to carriers, intermediaries. Do you agree with that?

Mr. STEWART. We would like to see some incentive payment provided if a fair method of determining the payment and a fair method of incentives could be arrived at. However, there are so many variables. I know that we have looked into it. For example, if you are just talking about a part A intermediary, what is the mix of claims that an intermediary would handle? For example, a bill or the processing of a claim for confinement in an extended care facility is much more difficult and time consuming than processing a bill for confinement in the hospital. So it would depend on the mix. Many providers have all hospitals, some providers have all ECF's, some have a mix predominantly in one direction or the other. We certainly would not turn our backs on an incentive payment.

Senator RIBICOFF. Have you any suggestions about the form these incentive payments would take?

Mr. STEWART. At this time I do not. I am working on a committee, as some of the other intermediaries and carriers are, trying to make suggestions as to what would be an appropriate incentive formula. So far we have come up with nothing, too.

Senator RIBICOFF. Do you have any thoughts or suggestions—if you don't have them now, would you like to make them to the committee—about some pilot programs for running medicare?

Mr. STEWART. As I indicated earlier, Mr. Pettengill testified before the House Ways and Means Committee, giving our proposals and various ideas on the broad health care problems, the manner in which to deliver health care, and how to finance it. The thing that we are trying to get across here is this problem with respect to extended care facilities.

Senator RIBICOFF. Yes. I mean in addition to what you are talking about is something that could be done on the national scale. I am thinking of some other ideas that any of you might have that we might try in three or four pilot programs throughout the different sections of the Nation that you might like to see tried. Do you have anything in mind?

Mr. STEWART. I am not prepared right at the moment, Senator. We are certainly interested in experimentation. We feel that is the only way we are going to improve. We would be very happy to submit to your committee those specific proposals that we might like to make. I am not prepared at this time to offer them.

Senator RIBICOFF. Either your company or the group of companies involved. I think we would be interested in some suggestions of alternative methods of payments or supervision that we could put into effect and try out to see whether they would work and might be a better system than we have now.

I follow Mr. Pettengill's testimony before the Ways and Means Committee but it is difficult for me to see how we could go to an overall insurance coverage under Government supervision of one sort or another or health services until we straighten out medicare and medicaid. There is no sense in putting the entire population into a system that is having so much difficulty with those over 65. So we better straighten this out before we can take the next step, if we do take the next step.

Mr. STEWART. Jim, did you want to say something with regard to this?

Mr. HUNT. Mr Chairman, I want to say that a proposal was made by the administration for a so-called part C in medicare for group practice. We are not sure what role insurers will play in that, if any, but Aetna has commented favorably on that proposal.

Senator RIBICOFF. You commented favorably in front of the Ways and Means Committee or independently?

Mr. HUNT. Independently.

Senator RIBICOFF. Would you send us a copy of that so we can make it a part of the record at this point?

Mr. HUNT. That support was in the form of a telegram.

(The telegram follows:)

President NIXON:

We have read with interest of the Administration's proposed modifications in Medicare and Medicaid which would include new emphasis on prepaid group practice plans. We understand that health insurers would be eligible to participate in the formation and administration of such plans. We support these proposals and would be interested in assisting in their development.

Senator RIBICOFF. Senator Williams.

Senator WILLIAMS. Mr. Stewart, I want to join Senator Ribicoff in complimenting you on your statement here. You have some very constructive suggestions and, as he said, you touched on some of the carrier problems which have been called to our attention: particularly, what may be a weakness in the program with respect to the person who needs extended care but yet does not need perhaps fairly intensive medical attention. The question has been raised that maybe some of these orders for physical therapy, for example, were meant to qualify him in the extended care facility? Do you agree?

Mr. STEWART. I agree. In the early part of the program, Senator Williams, there were many difficult areas of administration. You mention physical therapy. One of the problems that intermediaries discussed among themselves and with the Social Security Administration was the fear that physical therapy was being overutilized. However, at that time billing mechanism gave us no way of really knowing what

the physical therapy was being rendered. We knew that a certain amount of dollars was being spent on physical therapy but we did not know what it was.

Since the middle of last year we have taken it upon ourselves to develop a separate physical therapy form that is in addition to the prescribed billing form required by the regulations. We are requiring that every time the Social Security Administration billing form is submitted reflecting a charge for physical therapy that this form accompany it and that it outline in detail all of the various modalities that were given, the frequency, and the charge for each. With this information at hand we know the type of physical therapy, the frequencies with which it was given. Then our nurses and our doctors and our claim offices have something to review, have something to go on, and as a result we have refused payment on a considerable number of physical therapy treatments.

Senator Williams. I wondered if it sometimes is an incentive—not an incentive but used as a method by the doctor to qualify them in the nursing home. Maybe the law or regulations need changing; nevertheless, under the law it is not covered care that they are getting.

I noticed that in some of the areas where you are administering the program in Clearwater, Fla., for example, we had cases called to our attention in an HEW audit report of one individual receiving as many as five physical therapy treatments in 1 day ranging from $6 to $10 each. Those certainly would be considered very excessive, I am sure. Would you not think so?

Mr. Stewart. I certainly do, and under the system we are operating under now we would be aware of the frequency of the physical therapy; in other words, the 5 or 6 a day that you are talking about. Whereas early in the program all we had was a bill that set the charge for physical therapy for a period of whenever the bill was submitted monthly or biweekly, whatever it might have been, and it was x number of dollars, we now can have a means of better zeroing in and evaluating the appropriateness of the physical therapy.

I would like to make clear, Senator, that physical therapy is a covered service under the medicare program. It is overutilization that we are concerned with.

Senator Williams. That is what I am speaking of, overutilization.

In the north Miami nursing home I notice an example here of a 93-year-old gentleman, hospitalized for 18 days, but in the extended care facility for 83 days during which time he received $3,500.70 of physical therapy, $1,092 for speech therapy and $349.50 for occupational therapy.

Senator Ribicoff. I am surprised a man 93 years of age could stay alive with all that treatment.

Senator Williams. I was, too, but perhaps it is explained in that he got a physical therapy treatment the day he died.

Senator Ribicoff. The undertaker probably didn't have to lay him out.

Senator Williams. I just wondered what steps you are taking to make sure that these abuses do not happen because obviously you cannot give that much physical therapy to any individual, whether he is 93 or whatever age he might be. It has reached a rediculous stage and I wonder what can be done.

I notice in another report here that one of your facilities was holding a bingo class 1 day a week and charging the Government $15 for therapy while the patients are playing bingo. Now that was approved, apparently.

Mr. STEWART. Under our present procedures this would not be approved, Senator.

Senator WILLIAMS. Do you think you have procedures now where this can be picked up and it would be stopped?

Mr. STEWART. Yes, sir. At the present time every bill that is submitted to our claim office for payment is reviewed by a staff of medical personnel comprised of registered nurses and doctors, every claim.

Senator WILLIAMS. Mr. Stewart, of course you are familiar with the hearings we had earlier last year. I am sure you are aware of the fact that some of the cases which were coming under the jurisdiction of your company as an intermediary were subject to perhaps severe criticism. Have you taken recognition of those and have you taken proper steps to see what can be done to correct them?

Mr. STEWART. Yes, sir; we have taken steps. I would like to say that I do have some concern and this again is one of the reasons for our proposal. We are very satisfied that we are administering the program at the present time strictly in accordance with the continuous skilled service requirement. For example, in the 2 States where we have only ECF's our administrative expenses have naturally gone up because of more close surveillance and because of putting on medical personnel. Our administrative expenses in these 2 States in the second half of 1969 over the first half of 1969 went up $141,655.

Senator RIBICOFF. Do you feel that it would be wiser that whoever the intermediary is that is taking care of the hospital service should also take care of the extended care facility service?

Mr. STEWART. No; that is not what I am saying, Senator. I am pointing out that my concern is that our administrative expense has gone up for closer surveillance and as a result the extended care facility payments—the payments to the extended care facility—for the ECF benefits or nursing care benefits, if you will, in those two comparative periods was down roughly $6 million.

Senator RIBICOFF. In other words, the point is that the amount of money you receive, the higher the amount you receive sometimes mean the more money you save.

Mr. STEWART. Yes. Our administrative cost went up because we save more money, but the point is this: I am not convinced in my own mind that the program has saved that 6 million fewer dollars that we have paid out. All I know is that $6 million was not paid out in ECF benefits. I don't know whether three times $6 million was paid out in hospital benefits because the doctors realize that if they put them into our nursing homes where we were administering the program strictly in accordance with the regulations that the person would not get paid and they would have no way of taking care of them.

Senator WILLIAMS. That is the basis for the recommendation in the statement?

Mr. STEWART. Yes; so I do not think we should be deceived by saying cut down on your ECF benefit payments. We have got to look other places, too, to see if we are picking up that amount and more in other types of benefit payments under the program. So, as you say,

Senator, this is the reason for our recommendation. I think that we have to get to the individual beneficiaries, and I think we have to get to their families as well; we have to provide some incentive to them to want to be cared for in this less extravagant health-type institution. This is what we are trying to do through our proposal.

Senator WILLIAMS. Mr. Stewart, as one who was previously critical of what we thought was loose management I think you agree there has been not loose management, loose administration. I am not going to pursue that further because you have recognized this problem and I am sure that you are taking corrective steps. I was much encouraged by the constructive suggestions in your statement. That is the purpose of these hearings.

First, the cost is prohibitive, far more than any of us expected. We wanted to find out why, we want to see what steps can be made to correct the problems. We are not looking for scapegoats, but nevertheless the only way you can correct a problem is to recognize the problem where it exists. Both the committee and the gentlemen in the field have to recognize that there is a problem, that there has been abuse. We call it abuse—it is abuse from mismanagement or whatever, but we can correct it by working together. We cannot correct it if we just try to brush it off and yet know that it is there.

I have been encouraged particularly by some of the witnesses who frankly admit there was a problem in the manner in which they administered, and started taking appropriate steps. I was hoping that we could convince the administration here in Washington likewise. There has been some laxity there too. Once they recognize the problem they, too, can act. We in Congress may have to recognize possible deficiencies on this end.

I have no further questions.

Senator RIBICOFF. Thank you very much, Mr. Stewart.

Would you and your associates please remain for a few minutes to answer some questions from the staff.

The committee will stand in recess until further call by the Chair.

STAFF. We just wanted to ask a quick question about your carrier capacity inasmuch as you are making, apparently, according to your statement, good progress in your intermediary role. Last year the Bureau of Health Insurance I believe requested profiles on physicians who had been paid $25,000 or more, is that correct?

Mr. STEWART. Yes.

STAFF. Now Mr. Tierney, the Director of the Bureau of Health Insurance, testified here that he regarded the data requested as very elementary data and that it was basic to any kind of control system. I believe Aetna replied to the request with a comment that it would take them 9 weeks to respond; they did not have that kind of data, and that it would take them 7 or 8 weeks to collect it. Do you recall that?

Mr. STEWART. Yes. I recall that we could not supply it right away because we did not have the capability or had not been keeping records in that fashion.

STAFF. Do you have that now?

Mr. STEWART. Yes, we do.

STAFF. And you regularly analyze physician profiles?

Mr. STEWART. We are in the process of developing that capability. We have made a decision to take the Social Security Administration's model computer program for part B. We have already implemented this, as I mentioned in my testimony, in one of our part B offices and are in the process of putting it in the others this year. This model program that has been developed by the Social Security Administration has that capability built into it.

STAFF. Do you feel that there is a conflict of interest on the part of a carrier or intermediary with a subsidiary which operates nursing homes in which the insurance company may function in a carrier or intermediary capacity? This is a general question.

Mr. STEWART. Well, I think it all depends on the individual carrier and whether they operate in a manner to make it a conflict of interest. I certainly agree that there would probably be the question of conflict of interest.

STAFF. But you don't believe that there is necessarily an implicit conflict of interest in such situations?

Mr. HUNT. We would suggest that there is an implicit conflict of interest.

STAFF. Now you advocate prospective reimbursement of hospitals, which is sort of fashionable among witnesses these days. What assurances would the Government have, in prospective reimbursement, of expert, arms length bargaining? In other words, who is going to negotiate for the public in that situation? Does Aetna feel qualified to do that?

Mr. STEWART. Jon, would you care to address yourself to that question?

Mr. MCFATHER. Yes, I think we are qualified. In other words, we do have, I feel, the competent staff at this time. It may require more staff under such a program but certainly we have the nucleus at this time.

STAFF. To negotiate?

Mr. MCFATHER. To negotiate rates of that type, yes.

STAFF. So in eflect you would be an alternative to Blue Cross?

Mr. MCFATHER. Right.

STAFF. You say in your statement that you agree with the American Hospital Association's recommendation that medicare should share the cost of providing all services, including those not generally applicable to the medicare age group. Now in this drive for equity and equitable payment, would you also want to see commercial insurance pay for hospital care on a cost basis to get everyone on an even keel? Cross pay on a charges basis to get everyone on an even keel?

Mr. HUNT. Are you suggesting that we want to be on an even-Steven basis?

STAFF. You are suggesting that there should be no differential in medicare reimbursement.

Mr. STEWART. In other words, if you are saying do we feel that all third party payers and private patients should be paying the same thing, I think that is our position, yes.

STAFF. Charges or costs?

Mr. STEWART. Well, at the present time all of our policies, as you know, are on an indemnity basis where we pay charges. As long as they are the same, I don't think it would make any difference.

STAFF. If you have prospective reimbursement, in what way is that advantageous to the third party payer who pays on the indemnity basis?

Mr. STEWART. Well, you are comparing it with an indemnity basis. Of course on the indemnity basis the institution knows what it is going to get, it is going to get charges. At the present time under our policies an institution knows that we are going to pay its charges, provided the policy pays for the charges. Of course some of them do not. Under the perspective reimbursement method it would know in advance what it was going to get for taking care of patients. So I guess they would be similar, a similar situation. They could count on it.

STAFF. It really is not relevant to your general nonmedicare business?

Mr. STEWART. No.

STAFF. You were really proposing that for medicare situations?

Mr. STEWART. Yes.

STAFF. And hopefully as a mechanism for controlling——

Mr. STEWART. We are proposing as an alternative to retroactive cost reimbursement.

STAFF. Are you satisfied with the flow of information from the Social Security Administration to intermediaries and the information you get back? Do you get technical assistance that you think you will need to do a good job of administering as soon as you think you need it? Is there any way you might be able to improve on the contact work that you have with the Administration?

Mr. STEWART. I think that we have to admit that there are areas that we can improve in and I would hope that the Social Security Administration would admit that there is room for improvement there. I think that they have taken steps. I think that they are now assigning representatives to their regional offices that are in close contact geographically with intermediaries and carriers. I think that there has been gradual improvement all along in the program. I am not saying it cannot be improved on further but certainly it has been improved. It has not been going in the other direction.

STAFF. Do you know of any instance where you might suggest an improvement? We might want to submit it for the record.

Mr. STEWART. I cannot think of any right offhand.

STAFF. Please send it to the chairman.

The committee is in recess.

(Whereupon, at 4:20 p.m., the subcommittee recessed, subject to the call of the Chair.)

MEDICARE AND MEDICAID

TUESDAY, MAY 26, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Hon. Clinton P. Anderson (chairman), presiding.

Present: Senators Anderson, Hartke, Ribicoff, Williams of Delaware, Curtis, and Fannin.

Senator ANDERSON. The hearing will come to order.

Today and tomorrow we will continue the extensive review of medicare and medicaid which we have been conducting for many months.

Both programs have experienced serious and highly costly overruns. The Congress is confronted with the need to substantially increase payroll taxes in order to properly finance medicare and will, of course, do what is fiscally sound and responsible with respect to continuing medicare's ability to bring necessary help to millions of older citizens.

There is general dissatisfaction, however, that is far too many cases medicare is not getting the kind of health care service and administration we, and the beneficiaries, and the taxpayers have the right to expect. The causes of these problems are somewhat complex. In part, perhaps the statutes and regulations are at fault. In part, governmental and carrier and intermediary performance may be responsible. But there is no doubt that the providers of health care must bear a large part of that responsibility.

We have been reviewing and studying medicare and medicaid in an effort to pinpoint the problem areas and to develop specific solutions. These hearings are an important part of that effort.

We heard from the administration during February; we heard from carriers and intermediaries in April; and today and tomorrow we will hear from institutional providers and other organizations concerned with the provision of hospital and nursing home care.

Before we hear from the first witness, the American Hospital Association, it would be well to make two points crystal clear. First, medicare is here to stay. We will do whatever is necessary to make that vital program function efficiently and economically.

Second, medicare's problems are real and cry for solution. I believe we are long past the stage, however, where the Congress will accept cliches, generalities, and self-serving statements in lieu of specific, detailed, and concrete recommendations and suggestions. It is too late in the day for niceties. These are self-imposed ground rules which are vital if we are to succeed in our important work.

Witnesses have been asked to address their testimony, in general, to issues raised in the recent report of our staff on medicare and medicaid. The social security bill passed by the House last week will be considered by the full committee at a later, appropriate date.

Mr. Hahn, you are now recognized; would you please come forward.

STATEMENT OF JACK A. L. HAHN, PRESIDENT, METHODIST HOSPITAL OF INDIANA, INDIANAPOLIS, IND., AND PRESIDENT-ELECT, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY JOHN M. STAGL, DIRECTOR, PASSAVANT MEMORIAL HOSPITAL, CHICAGO, ILL.; AND KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, AND DIRECTOR, WASHINGTON SERVICE BUREAU, AHA

Mr. HAHN. Mr. Chairman, I am Jack A. L. Hahn, president of the Methodist Hospital of Indiana in Indianapolis, Ind. I appear here today as the president-elect of the American Hospital Association. With me on my left is John M. Stagl, director of the Passavant Memorial Hospital, Chicago, Ill. Also with me is Kenneth Williamson, deputy director of the American Hospital Association and director of its Washington Service Bureau.

I would like to present our entire statement for the record, but just read parts of it in making my testimony, Mr. Chairman.

Senator ANDERSON. Certainly. The statement will be printed in full. You may go ahead as you suggested.

Mr. HAHN. I will commence my remarks with our comments on the report of the staff of this committee on the medicare and medicaid programs and present our thinking in respect to the recommendations incorporated in that staff report. At the outset, Mr. Chairman, we wish to compliment this committee on directing that such a review and report be made; and we commend the staff on the depth of its study. We recognize that such a study and report is in keeping with the responsibilities of this committee for the operation of these programs. The hospitals of the country are well aware of the far-reaching problems discussed in the report and share the feeling expressed that a number of changes and improvements are needed in the programs. We have studied the report carefully and while we are in agreement with many of its recommendations, we have basic differences of opinion in respect to certain of them.

The medicare program has in our opinion been an outstanding success in terms of providing needed health services to the aged people of the country in a manner not available to many of them in the past. This view is reflected in the following statement which is taken from the letter of the chief counsel of the committee transmitting the report to the chairman of the committee—"Medicare is a good Federal program." The program owes much of its success to the dedicated support of the hospitals of the Nation and I can assure you, Mr. Chairman, that hospitals take great pride in the contributions they have made. Frankly speaking, I must say that hospitals are becoming increasingly disturbed at the mounting criticism directed at them—much of which

is unjustified. We believe the future success of the program depends on the ability of hospitals to continue to provide the needed facilities and services.

Before proceeding with our comments on the staff report, may I say that the association has requested an opportunity to testify at legislative hearings that we presume will be held later by the full Finance Committee on H.R. 17550, the social security amendments bill, which was passed by the House of Representatives last Thursday.

Senator ANDERSON. I agree that the members of our staff did some very fine work. A number of their recommendations to us are included in the House bill.

M. HAHN. Thank you, sir.

This statement addresses itself to the staff report in the order in which the staff report was prepared, and it is presented for your review and consideration by the staff and the committee, and I shall not dwell on each point. It deals first with the fiscal impact of medicare, with the fiscal impact of the medicaid program, with reimbursement of institutions providing medical care.

Over a 2-year period, the hospitals of the country have engaged in extensive discussions of a new basis of reimbursement that would provide for meeting the full financial requirements of health care institutions and would relate reimbursement to planning control. Following extensive discussions, a financial policy statement was approved by the association as a basis for payments to hospitals by all users of their services. Copies of this document, "Statement on the Financial Requirements of Health Care Institutions and Services," have been provided for each member of the committee.

I would also like to point out that we have discussed with the administration the cost savings that would result from greater use of average costs rather than the present method of formula determination.

Proceeding with the discussion of our statement on financial requirements, the Nation is spending more than $20 billion a year on hospital care and hospitals constitute the Nation's third largest industry. The American Hospital Association believes that the financing of institutional health care must be on a businesslike basis.

Most industries in our economy rely on operating revenues to finance the production of their products and the means of producing them. The financing of the health care system, however, has been chronically insufficient for hospitals to do this. Some institutions have been financed largely through community philanthrophy, many have had to rely on extensive borrowing, and others have been dependent on Government appropriations or grants. Only a few have been able to rely solely on operating revenues as an adequate source of funds.

The following pages discuss our statement on financial requirements more fully, and I shall not read them.

Turning to page 10 of our report, since the AHA statement on the financial requirements was approved, the association has worked locally with allied hospital associations, Blue Cross plans, and State welfare agencies in developing programs for implementing the principles set forth in the statement. It has also made national representation to the Department of Health, Education, and Welfare, the U.S. Congress, the Blue Cross Association, and the Health Insurance Council. From these experiences has come the conclusion that methods of

payments based on prospectively determined rates offer very real opportunities for meeting the objectives of public accountability, predictability, and preservation of institutional autonomy, as well as the other objectives of the statement.

On May 6, 1970, the board of trustees of the association adopted the following policy dealing with prospectively determined rates.

Mr. Chairman, the following pages discuss prospective reimbursement, including guidelines for developing prospectively determined rates, and the methods for such rates, which we think offer real promise for the implementation of this responsible means of reimbursement which we are suggesting.

To accomplish the objectives of the statement on the financial requirements, we make the following recommendation:

RECOMMENDATION

That section 1861(v)(1) be amended under the definition of reasonable costs as follows:

1. Delete clause (A) of the fourth sentence of such section and substitute therefor the following:

(A) take into account both direct and indirect costs of providers of services, provided, however, that the costs of new construction or expansion and the cost of providing new services shall not be included unless such new construction, expansion, or new service shall have been approved in advance by the designated areawide planning agency.

2.—

The term "reasonable cost" as used in this law shall mean the total monetary resources that a health care institution or service needs or will need to fulfill its role in meeting community health service objectives. When we state total monetary resources, we include consideration for both operating and capital requirements of the institution. The Federal government's share of these financial requirements for its beneficiaries shall not be more than nor less than the share borne by all other paying patients.

We feel that this is the only way to equity, by equal sharing of these total expenditures.

The report suggests that payment for care be equated on the basis of institutions providing comparable services. We would point out that such an approach will require substantial increased administration and will, therefore, be costly in itself. It would be necessary to certify in each individual case the comparability of patient care, the quality of the care, and the relative efficiencies permitted by the institutions concerned. A system of prospective reimbursement such as we have recommended would be more likely to obtain assurance as to reasonableness of the costs incurred.

REIMBURSEMENT OF COSTS UNDER MEDICAID

The staff report suggests a departure from the present practice of reimbursing hospitals under title 19 on the same basis as they are reimbursed under title 18. Legal counsel of the administration has reiterated at various times that both titles contain the same words "reasonable costs" and that it is impossible to interpret them differently. Their conclusion has always been that the basis for reimbursement must be the same under titles 18 and 19 as enacted.

It must be obvious to everyone that any reduction in medicaid payments to hospitals or failure to reimburse hospitals fully for the cost of care provided medicaid beneficiaries will increase the hospitals' charges for care to all other patients. This is a result the public is not willing or able to accept. Further, the administration—Mr. Veneman—has testified before this committee that it does not accept such an approach.

It has seemed to us that the objective of the Congress in enacting title 19 was to assure a system of equity in the provision of health services as between those patients who are able to pay and those who are not, with the further worthwhile end of assuring one system of health care in the country and not two. If the Congress is to attain this national objective it will be necessary for the Congress and the States to provide a system of financing that will enable hospitals to provide the needed care and services.

We therefore recommend:

RECOMMENDATION

If there is any doubt as to the requirement for full reimbursement to hospitals for care provided to medicaid beneficiaries, we urge the law be amended to make this requirement absolutely clear.

We next speak to bad debt collection as referred to by the staff report, and we speak of the difficulties the hospitals are encountering in carrying out their collection procedures.

Turning to page 19, we make a recommendation regarding deductibles. I quote our recommendation as follows:

"That deductibles be eliminated and that in their place the principle of coinsurance be applied to become effective at a specified point in an inpatient stay. The same principle should also be applied to outpatient services."

This is equally difficult for both the patients and the providers of service, and we strongly recommend that the insurance be changed to a coinsurance program.

Senator Anderson. We had quite a battle for awhile in the Congress with those who desired to eliminate the deductibles entirely.

Mr. Hahn. We do want to do away with deductibles entirely; yes, sir.

Senator Hartke. Mr. Chairman, I would like to ask leave to comment.

Senator Anderson. Senator Hartke.

Senator Hartke. I have been over to a House hearing, and I have to go chair a hearing on the aged. But Mr. Hahn is not alone from my home State of Indiana, he is a distinguished native of Evansville, Ind. I had the honor of having pledged him to my fraternity when I was at the University of Evansville, and I was a senior the year he was a freshman. His father was a distinguished hospital administrator before him. Incidentally, he occupied this position while he was totally blind and was one of the outstanding hospital administrators in the whole United States of America.

So it is with a great deal of pride that I find Jack Hahn now president of the American Hospital Association and find him testifying here today. I do have to leave, and I shall be back as soon as I can, but

I am chairing the hearings on the aging, which is very close to the problem which is being considered here today.

Senator ANDERSON. Thank you.

Mr. HAHN. Thank you, Senator.

On page 20 of our statement we speak to the depreciation allowances. The committee staff report recognizes the need of accelerated depreciation in instances where approved capital needs cannot otherwise be met. We believe such accelerated depreciation should be authorized to institutions meeting the following criteria:

A. Expansion or major modernization projects should have area-wide health planning agency approval, and

B. The financing of these approved projects entails the use of debt capital with amortization schedules shorter than the project's useful depreciation life.

We therefore recommend:

RECOMMENDATION

That the use of accelerated depreciation be authorized in the legislation under the criteria set forth above.

TAX-EXEMPT STATUS OF COMMUNITY HOSPITALS AND OBLIGATIONS TO PROVIDE CHARITABLE CARE

We are attaching hereto (app. A) a copy of the association's testimony presented to the House Ways and Means Committee on this matter.* It is our position that requiring a nonprofit hospital to provide some free patient care in order to be tax exempt is unjustified, and the struggle of the Internal Revenue Service in attempting to articulate a reasonable guideline for application of the exemption indicates that the requirement is unworkable. The tests that should be applied in determining whether a hospital is exempt are whether it is operated principally to provide hospital care and whether any earnings of the hospital inure to private persons. Once it is shown that the hospital's earnings do not inure to the benefit of any individual, the hospital should be exempt. The mere existence of the facility provides a basic service that would otherwise have to be provided by Government.

Educational institutions, college football games, symphonies, and jazz festivals are exempted from Federal income taxes. Their exemption is not measured by the degree to which they provide free services. Surely a hospital is as essential to the public welfare as any of the above-mentioned endeavors and a hospital's tax exemption should not be measured by the degree to which it renders free care, but rather on the basis that it is an available community resource and performs a public function.

Further, elimination of the tax exemption for hospitals would eliminate any hope of future donations by the public to health care and completely obliterate one of the last vestiges of encouraging and preserving private initiative in good works.

*See printed hearings entitled "Tax Reform, 1969," p. 1425, Committee on Ways and Means, House of Representatives.

We therefore, strongly oppose the recommendation of the staff that Revenue Ruling 69–945 be revoked, and we firmly believe that our position is totally in the public's interest.

We recommend:

RECOMMENDATION

That section 501(c)(3) of the Internal Revenue Code be amended to provide a specific exemption from taxation for nonprofit hospitals.

Senator RIBICOFF. May I ask just one question there that concerns me?

There are millions and millions of poor people who are not covered by medicare and medicaid and who have no doctors to turn to and no place to go. Do you feel that a hospital that is supposed to be community-based to take care of the needs of the people should turn away individuals because they have no money to pay for the services?

Mr. HAHN. No, we do not, but we do not think this should be the basis for tax exemption. We do feel that community-based hospitals do a tremendous amount of care of the indigent. I think this is proven across the land.

But we also feel that no one is refused admission in an emergency situation. The hospitals do have limited ability to meet these kinds of needs and must limit this to the degree of their financial ability. And in most instances, this can only be charged to other patients and not medicare patients, because medicare reimbursement does not cover provision of charity services rendered.

Senator RIBICOFF. I think there is something abhorrent in the thought that there is a community hospital that holds itself out to take care of the health needs of the people, and yet would feel free to turn away a sick person who needs care on the basis that they cannot pay for it. Now, I tell you, as far as I am concerned, I would not accept what you are saying under any circumstances. Maybe others in the Senate would, but I would not.

Mr. HAHN. I do not think the statement says, Senator, that we do not believe the hospital should render charity care. We do not think it should be the basis for tax exemption.

Senator RIBICOFF. Yes, but there are hospitals who might consistently turn them away and yet hold themselves out to the public to be a great charitable institution. I do not think any hospital should be in the position where it can be tax exempt, and yet refuse to give service to a person in need.

Mr. STAGL. I think, Senator, what this gets down to is the institution. For example, in Chicago, we have some hospitals that run one-third of their operation on a charity basis; Michael Reece, in Chicago, for example.

They cannot take any more because they have payrolls to meet. Medicaid in our area is not meeting the need, and there are others who do not fall under medicaid. The institution can be the best motivated in the world, but it comes to a certain point where the hospital cannot support more charity.

If you are referring to the institutions that deliberately do not take charity cases, I think that there would be very, very few across the country.

Senator RIBICOFF. But you are not asking for that. I think there is a great deal of difference in a hospital that provides one-third of its facilities to nonpaying charity patients. I do not think there is any question on a hospital such as you describe. But when you get a hospital that will not take any and say, "we provide a community service and should be tax exempt," that is a different situation.

Mr. HAHN. We know of no hospital that turns away emergency patients because they cannot pay.

Senator WILLIAMS. I think the point the Senator from Connecticut is making is that if such a hospital is found, you would agree that the tax exemption should be revoked, is that right?

Mr. STAGL. We do not see why that is the issue, Senator. The money does not inure to any individual.

Senator WILLIAMS. The point I am making, as does the Senator from Connecticut, is that the case you described, I do not think would even be questioned. But just suppose there was a hospital, and we will assume that there are none, but suppose there was a hospital that flatly refused to accept any charity patients at all. Under those circumstances should they continue to enjoy tax exempt status?

Mr. HAHN. Yes. If they had 99 percent medicare and medicaid patients, they would have to refuse charity patients, because medicare will not contribute to charity care and the hospital would have no other money to cover charitable patients.

Mr. STAGL. Are you referring, Senator, to the case that might not have any charity? For example, a suburban hospital might not have to provide it. And again, we would get to what we think is the heart of this issue, that the determination of tax exemption should be on what is done with the money after the year's operation. It does not go to any individual.

Senator RIBICOFF. How much money do all these hospitals get a year, from charitable contributions and from State, local, and Federal grants? It comes into the billions of dollars.

Now, I think the average person in a hospital drive who gives a stipend or a contribution assumes that one of the reasons he is giving this is because of some poor person who needs hospital care or is ill, and he is going to get care. Now, this is not money that you say just gets charged to the patient. You are receiving billions of dollars a year from the public, and if you are receiving billions of dollars a year from the public, I think the public is entitled to get the feel that those who cannot afford to pay are getting some sort of service from the hospital.

Mr. HAHN. Those contributions are usually given for a specific purpose, including the Government grants, and they are usually less than the cost of providing that service or the facility for which the contributions are given.

Senator RIBICOFF. But they are usually given in such large sums that were those sums not given, the hospital costs, the hospital facilities, would certainly be a lot more than they are today would they not?

Mr. STAGL. Those contributions would then be taxable, would they not, again?

Senator RIBICOFF. That is right. I think this is one of the great problems, and I think that there is a public responsibility on your part to take care of the needs of the indigents.

Mr. HAHN. We think that there is a need, too, and we think this is one of the reasons that our charity care should be included as a reimbursable cost under both medicare and medicaid, which is not the case at the present time. Those hospitals that are rendering a very large amount of charitable services are suffering in this manner.

Senator RIBICOFF. You see, the speciousness of your argument, sir, is this, that the passage of medicare and medicaid, this act, lifted a fantastic burden off of the shoulders of hospitals and doctors, because up until this time, a great share of the hospital costs were being borne by taking care of patients over 65 whose incomes are low and who were indigents. This money went for doctors who rendered services to the elderly and were not being reimbursed.

Suddenly, this became a bonanza. These billions of dollars poured in, reimbursed the doctors and reimbursed the hospitals for services that, prior to the passage of medicare and medicaid, you were not being reimbursed for. So medicare and medicaid poured billions of dollars into health facilities and physician services that up to now have not been reimbursed.

Mr. HAHN. I am sorry; the hospital I serve has rendered more charity service since the passage of medicare and medicaid than prior to that time. It now exceeds well over a million dollars a year.

Senator RIBICOFF. I cast no reflection on your hospital or any other individual hospital, but I think I am making a general statement that can be borne out by the facts that are actually in existence in America today.

Senator ANDERSON. Do you have a statement on this situation that you say exists?

Mr. HAHN. In my hospital? Yes, sir. I shall produce them for the committee and see that you receive them, sir, the charitable services that have been rendered by the Methodist Hospital of Indiana in Indianapolis during the sixties.*

Senator RIBICOFF. And supplementing the chairman's request, I would like you to submit the amount of money received by American hospitals in charitable contributions and in Federal, State, and local grants.

Mr. HAHN. You are asking us what?

Senator RIBICOFF. American Hospital Association, if you have those figures. You must have some listing of statistics of the amount of money American hospitals received in charitable contributions, and also in State, local, and Federal grants.

Mr. HAHN. I am not sure we have these figures.

Senator RIBICOFF. Well, if you do not, you do not.

Mr. HAHN. If we do, I shall submit them to the committee.*

May I proceed, Mr. Chairman?

Senator ANDERSON. Proceed.

Mr. HAHN. On pages 23 and 24 and 25 is a discussion of the difficulties in operation of part B, our statement on payment for physicians' services, and on page 26, we recommend that parts A and B of title XVIII of the Social Security Act be combined in a single program to provide institutional health care services and physician services.

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*See AHA letter to the chairman, p. 421.

Senator ANDERSON. What is the reason for that recommendation?

Mr. HAHN. We think the present complexities of operating under parts A and B cause considerable administrative expense from both the standpoint of the administration of the act and within the institution itself.

Mr. WILLIAMSON. We think also that it should be possible for a worker to prepare for and store up funds for physician services in the same manner he does for institutional services. The aged should not have to face payment and have ability to pay funds in order to get physicians' services when he reaches retirement. He ought to have the assurance of those services, just exactly as he has the assurance of institutional services.

Mr. HAHN. On page 27, payments to "supervisory" physicians in teaching hospitals and large payments to health care practitioners.

We believe that the law should provide for the payment of all physicians' services rendered to beneficiaries. We further believe that the Government should take whatever steps are necessary to prevent any abuse in payments for physicians' services.

We next describe incentive reimbursement methods.

The association and numerous hospitals throughout the country have been earnestly working at the development of incentive reimbursement programs. We include some of those in appendix B submitted to the subcommittee, such things as shared services, nonsalary expenses, ambulatory care, and incentives for employees for increased productivity.

It should be recognized, however, that although there are areas of hospital operation where modern technology can be and is being utilized fully, there are definite limitations in this regard because the best in hospital care represents the best in personal human services.

Senator CURTIS. May I ask a question?

Senator ANDERSON. Yes, Senator Curtis.

Senator CURTIS. Your recommendation on page 27, which says "We believe that the law should provide for the payment of all physicians' services rendered to beneficiaries."

What would be the additional cost of that?

Mr. HAHN. We think that the law does provide for this and there should be recognition of this fact. I think we are primarily talking about teaching physicians who render direct patient care and are not otherwise reimbursed.

Senator ANDERSON. It is pretty clear in the statement, is it not?

Senator CURTIS. What services are rendered to beneficiaries that are not reimbursed by medicare now?

Mr. HAHN. We think that there are questions being raised about the reimbursement of physicians who provide services primarily to patients who are cared for in cooperation with intern and resident physicians and we believe that when direct patient care is rendered by those physicians, that they are covered under the act, and they should be reimbursed. We are really answering the question that has been raised in this regard?

Senator CURTIS. In reference to that Chicago situation?

Mr. HAHN. I think that Chicago situation was a question that was raised. I do not think that this is the situation specifically that we are

referring to. We think in certain instances, the services can be proved and should be reimbursed.

Senator ANDERSON. Who guarantees the payment?

Mr. STAGL. Medicare, I think, or medicaid.

Senator CURTIS. Now, would this be paying for something that the patient did not pay before?

Mr. HAHN. When the patient was a pure charity patient, the patient did not pay for it. But many of the medically indigent patients have carried some partial insurance programs, and they have paid for it through those physician coverage programs.

Senator CURTIS. No, my question is, When someone goes to the hospital and pays their own bill and they also pay their own doctor, have they in the past been billed for services rendered by interns and doctors that are in training?

Mr. HAHN. No. Interns and residents, sir, are part of the hospital costs for which hospitals are reimbursed under part A. Those other patients have paid for that expense in their regular daily service charge as part of the charge for service. It has been part of the hospital's bill.

Senator CURTIS. I asked you what you meant by this sentence, "We believe that the law should provide for the payment of all physicians' services rendered to beneficiaries."

Your reply is that they are all paid now except residents and interns.

Mr. HAHN. That was not the intent of my answer.

Senator CURTIS. What services are you talking about that are not now paid and that you are recommending medicare be extended to include?

Mr. STAGL. To go back, Senator, the reason for this remark was because there has been some question, including the Chicago situation, about whether an attending physician should be paid for services that he gives the people who used to be indigent patients. All we are saying here is, taking a position in view of this controversy, that we believe that what is in existence today should continue to be in existence, which is to say that if a physician renders service to an individual, he has a right to be paid for that.

Senator FANNIN. Mr. Chairman, I would jut like to ask a question.

Is there a different policy followed now than was followed before medicare and medicaid in that respect?

Mr. STAGL. In the case of the physicians, yes; but also in the case of hospitals, because before medicare or medicaid came on the scene, if Mr. Hahn had an indigent patient, that patient paid for neither professional services nor hospitalization. Now medicare and medicaid have come on the scene and the hospitalization is paid for, and presumably also the physician.

Senator FANNIN. I do not think you are responding to my question. Do you follow a different policy in the hospitals as far as the basis of charging—not the amount, but I mean the basis of charging, as you are talking with an intern or talking about the other assistance in the hospital? Or do you follow the same policy today that you followed before medicaid and medicare?

Mr. HAHN. Yes, sir.

Senator FANNIN. That is the question.

Mr. Chairman, one other question.

Are you familiar with the bill that I introduced to provide medical and hospital care through a system of voluntary hospital insurance?

Mr. HAHN. I am not sure I heard you.

Senator FANNIN. Are you familiar with a bill, S. 2705, to provide for medical and hospital care through a system of voluntary health insurance, where the indigent patient would receive a certificate from the Government that would pay his insurance. It would be a voluntary program to replace medicaid, because there are two cases where we do not have medicaid, as you know, Arizona and Alaska. I happen to be from Arizona, so we are vitally interested in this from that standpoint; also of the tremendous cost of medicaid.

Have you studied the program that would be involved in voluntary health insurance?

Mr. HAHN. No; we have not. I understand the principle that you are expressing, but we are not familiar with the bill.

Senator FANNIN. It would be on the ability to pay; in other words, whether or not the patient had the ability to pay, his income would determine the percentage that would be assumed by the Federal Government.

Well, I would like to submit the bill to you and then would very much appreciate a statement for the record as to your conclusion as to the benefits that this bill would bring about.

Mr. HAHN. We appreciate the opportunity to do this, Senator.*

Senator WILLIAMS. If I may, just on the question of Senator Curtis', I am not sure I understood your answer.

Prior to medicaid and medicare, if you had a patient who was paying for the services, paying all his doctors and the hospital and all, well able to pay, would you charge that patient for the services rendered by an intern?

Mr. HAHN. It is considered a part of the basic hospital charge. Interns and residents are paid a stipend by the institution, and the cost of the intern and resident service is included in the hospital costs that make up the daily service charge to all patients in the hospital.

Senator WILLIAMS. And it was not charged separately as physician's fee?

Mr. HAHN. No: not a separate physician's fee.

Senator WILLIAMS. And you do not think it should now, either?

Mr. HAHN. No: we think it should be a part of basic costs as it is now under part A.

Continuing now on page 29, we have addressed ourselves to the certification of extended care facilities. We believe that an extended care facility is an extension of an acute general hospital and that the necessary services can be provided patients in such facilities only if the extended care facility is a part of or is located in close proximity to a general hospital.

Turning to page 30, there are increasing reports, however, that extended care facilities are not being utilized or are being underutilized in various parts of the country. This apparently is due in part, to the administration's recent actions rejecting payment for large numbers of patients certified by physicians as being eligible for care in extended care facilities. We are further told that this has led to longer stays in

*See AHA letter to the chairman, p. 421.

acute general hospital beds for some patients. A thorough review and analysis of the present situation and ways of ameliorating it are ur gently needed.

Gentlemen, this is an excellent potential for savings that has taken a negative turn.

Senator RIBICOFF. You see, what bothers me on this statement, what the staff concluded was that a doctor would take a walk through an extended care facility and within a half hour, see 20 patients and send 20 bills for services rendered, and all he said was, "How are you today?" Are you contending that once the administration clamped down on this practice, no doctors are being reimbursed for taking a walk through a ward and saying, "Hello" in a general hospital and getting the same type of payment and that is why they are keeping their patients in general hospitals?

Mr. HAHN. No, we think there is a very close scrutiny of extended care facilities to the degree that many patients who should not be in the general hospital but should be receiving extended care are turned down for the institutional part of their care. We are not speaking to the physicians' services; we are speaking to the institutional reimbursement.

We think that because of the kind of scrutiny that is being emphasized in the extended care facilities, physicians are reluctant to transfer their patients out of the acute care hospital and more extensive care hospital to the extended care facility. We do agree that there are some nursing homes that do not meet the standards of extended care facilities, and we think that is important.

Senator RIBICOFF. The nursing and extended care facilities contend that the general hospital keep their patients longer than required to fill up empty hospital beds as a higher cost, instead of sending them to extended care facilities.

So bascially, what we have here that is really causing so much concern in the committee is that every phase in the entire chain of health care is being abused. This has caused a fantastic increase in expenditures—way beyond the estimates. I would suppose that at the time there was an assumption that the health care being given to medicare and medicaid patients would have been on the same basis that they were being utilized in the past. But now, once medicare and medicaid came in, the abuse is all the way down the line.

How do you get the self-policing of the hospitals, the extended care facilities, the doctors, the nursing homes, to keep the costs in check?

Mr. HAHN. Well, we feel that there are empty extended care beds because physicians are reluctant to transfer their patients there because of the manner in which this utilization has been reviewed. We think that some of the review has been so inappropriate that they are keeping the patients in the general hospital, and we do not agree that this should be done. We agree that they should be transferred to the less expensive bed.

Senator RIBICOFF. Well, the responsibility is the physicians' then, in this case?

Mr. HAHN. Yes; but we think the administrative review of the use of extended care facilities has been overdone, to the degree that it has lost its intended purpose.

Senator RIBICOFF. But the administrative review just has occurred in the last few months, when the committee called attention to the abuses. Yet the problem existed long before these administrative changes.

Mr. HAHN. We think that the problem has multiplied since that review, whatever problem existed previously.

Senator RIBICOFF. What kind of review board should there be locally to make sure that there are not abuses anywhere down the line? How would you envisage a review board on a local basis to protect the public interest?

Mr. HAHN. We have recommended internal peer review for utilization, as has been the practice, in promoting——

Senator RIBICOFF. Internal review in each institution?

Mr. HAHN. Yes.

Senator RIBICOFF. How do you coordinate the institutions? From what you have been saying, each institution places the blame on the other institution. How do you coordinate the activities of health care facilities in their entirety to eliminate the abuses all the way down the line?

Mr. HAHN. I would think that a hospital that operates its own extended care facilities should have a joint utilization team that works for both. I can see how a hospital that has a close affiliation agreement with a closely geographically related extended care facility, could well have a joint utilization team that would be concerned equally with patients of both.

Mr. STAGL. I think, also, Senator, in the text, where we indicate that the extended care facility should be part of or affiliated with the institution, there results inducement for the sort of thing you are talking about. The hospital that also has an extended care facility has no great incentive to hold the patient in either place.

Senator RIBICOFF. That is fine, but what percentage of hospitals today have their own extended care facility?

Mr. STAGL. I think that is a growing percentage.

Mr. HAHN. Many of them started early in the program, and many of them are now becoming disenchanted with it because of the manner in which it is being administered.

Senator RIBICOFF. When you say administered, that is the Social Security Administration?

Mr. HAHN. Yes, sir.

Senator RIBICOFF. Or the hospital?

Mr. HAHN. No, sir; the Social Security Administration.

Senator RIBICOFF. In what way is it being abused by the administration?

Mr. HAHN. We think they are rejecting cases that should be accepted.

Senator ANDERSON. Do you have figures to show that?

Mr. HAHN. We do not have any figures, Senator, to show this; no. It is the opinion expressed by many hospitals in activities within the association.

We do address ourselves to utilization in the next section in our statement, starting in the middle of page 30, Institutional Utilization Review Mechanisms.

We believe that the process of utilization review is beginning to show real results in controlling the utilization of hospital facilities. The procedure is generally being developed so as to apply to all patients and not just to those who are the responsibility of the Federal Government. In some institutions utilization review has brought about a marked improvement in the use of facilities. The most recent data compiled by the research staff of the association shows that since January 1, 1968, there has been a gradual reduction in the average length of stay of aged patients in general hospitals throughout the country. We believe this is to some extent attributable to the growing effectiveness of utilization review.

Much needs to be done to improve and strengthen the utilization review process. We have a group at work outlining procedures which they think will accomplish such improvements and which we then intend to urge upon the hospital field. This group is aware that a particular problem exists in rural areas and in smaller hospitals.

In our appearance before the House Ways and Means Committee last October we stressed that reports from around the country indicate that the effective functioning of utilization review committees is hampered because of the concern of physicians serving on such committees as to their personal legal liability. The Social Security Administration continues to point out that the function of utilization review committees is only to determine any future responsibility of the Government for the payment of care, and not to force the discharge of patients. This simply begs the question. The utilization review mechanism is of primary importance to the financing of the medicare program and should be improved.

We therefore recommend:

RECOMMENDATION

That the Federal Government study the matter of the personal legal liability of physicians serving on utilization review committees and adopt such steps as are necessary to remove the concern of physicians in this regard.

Senator Ribicoff. I think that is a good suggestion, but I am just wondering, would this be subject to State action or Federal action? That is what bothers me here. If we passed a Federal law excluding liability, do your legal counsel indicate that that would carry over to State liability?

Mr. Stagl. I really do not know.

Mr. Williamson. No. I think, Senator, we have to go to the States, but we think the Federal Government could go to the States itself, also, and promote the idea that physicians serving on these committees for medicaid and medicare as well, which they are deeply involved with, should protect them against the kind of capricious suits which they believe they are faced with.

Senator Ribicoff. The staff points out that you could, under title XIX, make this a condition to State plan if the State adopts the law. I think what you find is hampering effective review; it would seem that this is a recommendation worthy of consideration by the committee.

Mr. HAHN. Yes, sir. The Federal Government has used the State governments for the utilization process mechanism, and we think that they could emphasize this and it would be most helpful.

Mr. WILLIAMSON. What we find, Senator, California is a good example, where physicians and hospitals—physicians, particularly—are sued at the drop of a hat now. What they find is if they participate in utilization review, in spite of what the administration says, it may end up in that utilization review committee saying, "This patient does not need to be cared for any longer." When they do so, then they are open to what may happen to the patents and which can be attached to the fact that they reached such a decision, and they want to be protected. We think it is quite a reasonable request.

Senator ANDERSON. Have there been any suits filed?

Mr. WILLIAMSON. We have not checked the number, Senator, but we are told there have been in that State. Or at least, there has been a lot of threat, and I do not know how many suits actually have come from it.

Senator ANDERSON. Has there been any suit filed?

Mr. WILLIAMSON. We have been told there have been; yes, Senator.

Senator ANDERSON. Where?

Mr. WILLIAMSON. In the State of California.

Mr. HAHN. Continuing on page 32. "Medicare fiscal intermediaries and medicare carriers," we believe that the fiscal intermediaries have performed a most important task in behalf of the medicare program and everyone concerned with that program. We do have some disagreement with the report of the staff.

On page 33, you find our recommendation:

That the providers of institutional health care services continue to be given the right to select their fiscal intermediaries.

QUALITY OF ADMINISTRATION OF MEDICARE

As we have already stated, the excessive administrative costs involved in accounting and auditing "overkill" and in the detailed procedures of the present program ought to be eliminated. We wholeheartedly agree with the intent of the fourth suggestion in this section of the staff report that everyone concerned "should be relieved of as much data gathering and report making as possible . . ."

Senator RIBICOFF. How much do you think you would save in your hospital if you did not have to do all this redtape? What do you think the costs would be, say, in your own hospital?

Mr. STAGL. Senator, there is a study underway now going to the all-inclusive rate, which would eliminate posting, billing, all sorts of things. Some of the figures that I have seen so far are pretty fantastic.

You take 8,000 hospitals across the country and eliminate one person per hospital alone at $5,000, and you have some figure. They had a study of a Toronto general hospital, which has 44 people in its office function, as against Massachusetts General, which has 120 people, both about the same number of beds. This will give you an idea of the kind of thing we are talking about.

Senator RIBICOFF. In other words, you are being inundated with redtape, with probably no one doing anything about the reports that you are filing anyway?

Mr. Hahn. We turn to page 35, "Medicaid administration."

As we view the overall operation of the medicaid program, we believe many of its difficulties stem from the fact that there was a rather complete underestimation of the likely impact of the program and the size of the administrative job that would be entailed. When one realizes that the medicaid program potentially may involve twice as many beneficiaries as are covered under the medicare program, then the administrative machinery established for the medicaid program appears grossly inadequate. The problem is given further emphasis when it is realized that the total dollar volume of the medicaid program, which has nowhere reached its potential, is now approaching the cost of medicare.

State hospital associations throughout the Nation work closely with official State agencies in the operation of the medicaid program. They have indicated in a recent survey that one of the major problems facing the medicaid program is the ineffectiveness of the advisory bodies established by the States. These advisory groups are in many cases not composed of the sort of representation that appears to be essential to fulfill their advisory role and often do not function in a manner that contributes to the continuing development and improvement of the program at the State level. Frequently they are simply used as rubberstamps for State officials. Much more effective and stringent Federal standards are needed to assure the proper use of State advisory bodies in the administration of the medicaid program in the States.

We continue to feel that health programs for the indigent and medically indigent should be run by health agencies and not by welfare agencies. Very different philosophies and skills are required for administering health programs as contrasted to welfare programs. Because of their experience, proposals have been made to utilize the machinery of voluntary health insurance organizations to handle the overall administration of medicaid. In fact Blue Cross plans are involved in the administration of the medicaid program in a number of States. An advantage of this is that it gives the Government a way of knowing exactly and in advance what the cost of the program will be for a given period of time.

The challenge to the Government is to establish a program which will meet the health needs of the poor. These needs will not be lessened by the Government simply deciding to spend less money than is necessary to meet them. If the Government establishes a program that provides a maximum of 5 days of hospital care, who helps the poor person who needs to spend 14 days in the hospital? This would simply mean that the Government is expecting somebody else to take over the responsibility and the hard fact is that there simply are no "somebody elses" left.

Senator Anderson. I wonder if you could summarize the rest of your testimony? Our time is getting short and we have some other witnesses.

Mr. Hahn. All right.

On pages 37 and 39 of our statement we comment on other areas of the staff report.

On page 39 to page 43, we present a number of recommendations that we think are important in the future of the program—such things

as appeals, the spell of illness concept which we think should be dropped, posthospital extended care services, coverage for all over 65, and reimbursement to extended care facilities.

On page 43 of the statement, we make a strong statement regarding hospital costs. We urge the committee to review it, and also the staff. We have submitted an appendix which addresses itself to statistical detail that covers this portion.

On page 45, we start our discussion of the health cost effectiveness amendments, and from pages 45 to 50, we comment on seven of these recommendations.

We state again our support of the planning mechanism, but we point out that planning should also give consideration—if planning is done on a recommendation basis, it should also recognize the full requirements of the institution financially for programs that are approved by official planning agencies.

In closing, gentlemen, we greatly appreciate the opportunity of presenting these views of the American Hospital Association to the committee. We will be glad to answer any other questions or furnish any additional information, such as you may request, which will be helpful to the committee in its deliberations.

(The prepared statement with appendix follows. Hearing continues on p. 414.)

PREPARED STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Jack A. L. Hahn, President of the Methodist Hospital of Indiana in Indianapolis, Indiana. I appear here today as the President-Elect of the American Hospital Association. With me is John M. Stagl, Director of the Passavant Memorial Hospital, Chicago, Illinois. Also with me is Kenneth Williamson, Deputy Director of the American Hospital Association and Director of its Washington Service Bureau.

I will commence my remarks with our comments on the report of the staff of this Committee on the medicare and medicaid programs and present our thinking in respect to the recommendations incorporated in that staff report. At the outset, Mr. Chairman, we wish to compliment this Committee on directing that such a review and report be made; and we commend the staff on the depth of its study. We recognize that such a study and report is in keeping with the responsibilities of this Committee for the operation of these programs. The hospitals of the country are well aware of the far reaching problems discussed in the report and share the feeling expressed that a number of changes and improvements are needed in the programs. We have studied the report carefully and while we are in agreement with many of its recommendations, we have basic differences of opinion in respect to certain of them.

The medicare program has in our opinion been an outstanding success in terms of providing needed health services to the aged people of the country in a manner not available to many of them in the past. This view is reflected in the following statement which is taken from the letter of the Chief Counsel of the Committee transmitting the report to the Chairman of the Committee—"Medicare is a good federal program." The program owes much of its success to the dedicated support of the hospitals of the nation and I can assure you, Mr. Chairman, that hospitals take great pride in the contributions they have made. Frankly speaking, I must say that hospitals are becoming increasingly disturbed at the mounting criticism directed at them—much of which is unjustified. We believe the future success of the program depends on the ability of hospitals to continue to provide the needed facilities and services.

COMMENTS ON THE STAFF REPORT

Fiscal Impact of Medicare (1)

This section deals with the assumptions and estimates of costs made at the outset of the program. As indicated, the costs of the program have gone far above the original estimates. Part of this is due to increases in the cost of care

provided and part is due to the inadequacies of the original cost estimates made by the government.

As we viewed the development of the medicare program, it appeared to us that first a tax rate was decided upon and then an attempt was made to provide a benefit program to fit those estimates; rather than first deciding on the benefits and then realistically projecting the costs of fulfilling those promises and determining the consequent tax rate required.

This section also discusses Part B of the program. We share the concern expressed that increases in the costs of Part B of the program have to be matched by the elderly, many of whom can ill afford it. We intend later to make specific recommendations on this point.

Fiscal Impact of Medicaid Program (2)

As the hospitals of this country worked with State authorities in the implementation of the medicaid program they found that the States conceived of it as a completely open-ended opportunity to provide health services to eligible recipients. The federal government literally said to the States—We will provide matching funds for the costs of whatever program you may decide upon within certain broadly described guidelines. To the best of our knowledge the medical care and services provided under the medicaid program are necessary and in fact in many States the scope of the program has been far too limited to meet the needs. There is no way administratively to control expenditures of the program except as the Congress establishes limitations on the scope of the program.

Reimbursement of Institutions Providing Medical Care (3)

We share the concern expressed in the report with regard to the fact that even after three years had passed, a great many hospitals had received no final confirmation from the Social Security Administration of their costs for the first year of the program; that only a very small number had any confirmation on their second year's experience; and that practically no hospital had any final confirmation of its third year's experience. This situation appears to persist.

One of the major causes of this is the extensive, detailed, costly and needless auditing procedures demanded by the Social Security Administration. This extensive auditing is a major frustration to all the institutions concerned and involves excessive administrative costs that are out of all proportion to any benefit derived by the government. It is our estimate that the costs required to comply with the current medicare reimbursement regulations amount to more than $150 million a year in hospitals alone and the federal government is bearing only a part of this cost. In addition, there are significant review and auditing costs borne by the intermediary which bring the total cost of administering the program to well over $\$\frac{1}{4}$ billion a year and this does not include the government's own administrative costs.

The staff report recommends a definite attack on this problem. We strongly agree with the recommendation for acceptance of one audit for each institution. Such an audit could be made by a certified public accounting firm as a public audit which would be relied on by all interested parties. It is highly essential that the extent of the audit recognize the varying sizes and capabilities of the institutions. The government could if it desires conduct sample audits of selected institutions.

We have also discussed with the Administration the cost savings that would result from a greater use of average costs.

Over a two-year period the hospitals of the country have engaged in extensive discussions of a new basis of reimbursement that would provide for meeting the full financial requirements of health care institutions and relate reimbursement to planning control. Following extensive discussions, a financial policy statement was approved by the Association as a basis for payments to hospitals by all users of their services. Copies of this document, *Statement on the Financial Requirements of Health Care Institutions and Services*, have been provided for each member of the Committee.

The nation is spending more than $20 billion a year on hospital care and hospitals constitute the nation's third largest industry. The American Hospital Association believes that the financing of institutional health care must be on a businesslike basis.

Most industries in our economy rely on operating revenues to finance the production of their products and the means of producing them. The financing of the health care system, however, has been chronically insufficient for hospi-

tals to do this. Some institutions have been financed largely through community philanthrophy, many have had to rely on extensive borrowing, and others have been dependent on government appropriations or grants. Only a few have been able to rely solely on operating revenues as an adequate source of funds.

The American Hospital Association reasoned that an ideal method of financing institutional health care should recognize:

1. The institution's responsibility to the community;
2. The need for systematic financing of all of their operating and capital needs;
3. A rationale for proper planning of facilities and services with due regard for regional variations;
4. Incentives for economy and efficiency in the delivery of high quality health care; and
5. The necessity for the maintenance of equity and the protection of the interests of both provider and purchaser.

This financing method takes cognizance of the differences between the institutional health care system and the rest of the economy. In the free market, industry can alter either price or quality in order to assure that current revenues are adequate to meet operating and capital needs. Health care institutions do not have these options. If the quality of health services is to be maintained, the prices established through bargaining between individual providers and large groups of purchasers must provide revenues sufficient to finance these services.

The institutional health care system differs from the rest of the private sector in its philosophy toward persons who are unable or unwilling to pay. Other members of the private sector maintain their right to not sell their product to someone who cannot afford it or is unwilling to pay for it. Community hospitals, because of their unique public responsibilities, do not have the freedom of such simple decision. These hospitals in order to continue to meet the health needs of the communities they serve must, of course, remain fiscally responsible.

Because of the significant problems in financing patient care operations created by nonpaying patients, because of the necessity to maintain standby services, and because of the cost involved in meeting the research and educational responsibilities of health care institutions, the limited capital payments that are currently included in contractual reimbursement schemes often must be diverted toward meeting operating needs. Thus, the health care system has had increasing difficulty in maintaining and expanding its capital facilities.

The Statement on the Financial Requirements corrects both operating and capital deficiencies by obligating all purchasers of care to share equally in meeting all the operating and capital needs of the institution providing the care. It recognizes that health care institutions cannot ask all purchasers of care to participate in their capital financing needs without the institution's full participation in the community's health planning mechanism and recognition of the institution's role in the delivery of health care to the community. Although a basic implication of the *Statement on the Financial Requirements* is expansion of the federal government's role in financing the care of the aged and indigent through the medicare and medicaid programs, the aggregate effect of such a rational systematic approach to financing is unlikely to significantly increase total federal payments, because this systematic approach will result in a more equitable determination of payments for all purchasers and a more effective distribution of payments among all providers.

The American Hospital Association seeks a payment system that recognizes a planned approach to the financing of institutional health care priced through negotiation between providers and purchasers; distribution of capital dollars only where there is demonstrable need; incentives for efficient operation; and the recognition of an institution's full operating and capital needs by all purchasers of care through equal payment for equal services.

Since the *Statement on the Financial Requirements* was approved, the Association has worked locally with allied hospital associations, Blue Cross plans, and State welfare agencies in developing programs for implementing the principles set forth in the *Statement*. It has also made national representation to the Department of Health, Education and Welfare, the U.S. Congress, the Blue Cross Association, and the Health Insurance Council. From these experiences has come the conclusion that methods of payment based on prospectively determined rates offer very real opportunities for meeting the objectives of public accountability, predictability, and preservation of institutional autonomy, as well as the other objectives of the *Statement*.

On May 6, 1970, the Board of Trustees of the Association adopted the following policy dealing with prospectively determined rates.

Policy on the Implementation of the Statement on Financial Requirements of Health Care Institutions and Services

Approved by the Board of Trustees May 6, 1970

The *Statement on the Financial Requirements of Health Care Institutions and Services*, as approved by the House of Delegates on February 12, 1969, states that "no one method of payment has emerged that combines the strengths and eliminates the weaknesses of all others." Method of payment is defined in the Glossary of Terms as "the means for apportioning among all purchasers of care their share of the financial requirement of the health care institution of service." The document also states that financial requirements may be measured either prospectively, i.e., prior to the rendering of service, or retrospectively, i.e., after services have been provided.

Traditionally, self-pay patients have paid on the basis of prospectively determined rates for actual services received while most contracting agencies have paid for services on a retrospective cost basis of reimbursement. These retrospective methods have been criticized as costly from an administrative standpoint, as ineffective in controlling costs, and as lacking positive incentive for cost containment.

Since the House of Delegates' approval of the Statement on Financial Requirements, the American Hospital Association has worked locally with allied hospital associations, Blue Cross Plans, and state welfare agencies in developing programs for implementing the principles set forth in the statement. It has also made national representations to the Department of Health, Education, and Welfare, the United States Congress, Blue Cross Association, and the Health Insurance Council. From these experiences has come the conclusion that methods of payment based on prospectively determined rates have very real opportunities for meeting the objectives of public accountability, predictability, and preservation of institutional autonomy, as well as the other objectives of the Statement on Financial Requirements. Therefore, the American Hospital Association and its member institutions should make immediate efforts to develop workable methods of prospective payment to meet the above objectives and to hasten the implementation of the *Statement on the Financial Requirements of Health Care Institutions and Services.*

I. Guidelines for Developing Prospectively Determined Rates

The following principles should guide the development of prospectively determined payment methods:

1. The rates of payment for services during a specific period of time should be determined and agreed upon prior to rendering service.
2. The prospective rates should be in accordance with the principles set forth in the *Statement on the Financial Requirements of Health Care Institutions and Services.*
3. In each individual institution, the prospective rates should result in apportionment of financial requirements without discrimination among all purchasers of care with equal charges for comparable services.
4. The establishment of prospective rates must be supported by current and predicted costs derived through appropriate budget and accounting systems.
5. Institutional performance measurements and comparative evaluations should be based on operating cost rather than full financial requirements; the nonoperating financial requirements should be separately evaluated.
6. In designing the payment system, consideration should be given to the method of handling any significant unbudgeted gain or loss in the previous period.
7. Provision should be made for a mechanism for determining emergency adjustments of prospectively determined rates.
8. Appropriate appeal mechanisms should be established to protect the rights of all parties.
9. The organizational entity responsible for administrative control over the payment process should be established on a statewide basis with appropriate local involvement in the determination of rates.
10. In designing and administering the payment method, cognizance should be given to the continuing relationship betweeu provider and purchaser.

II. METHODS FOR PROSPECTIVELY DETERMINED RATES

Controlled charges could be established through a rate review and approval process. This method, based on the following criteria, appears, at this time, to be the method of payment most consistent with the guidelines:

1. The rate review agency should be constituted geographically on a statewide basis; however, there may be one or more rate review agencies within that area. The rate review agency may be either voluntarily or governmentally organized. If voluntary, it should be composed of equal representation from the public, contracting agencies (or their agents), and health care institutions. The public representatives should be chosen by the representatives chosen by the other two parties.

2. The health care institution should propose prospectively a schedule of the necessary rates including supporting data for services to be rendered on the basis of the institution's demonstrated financial requirements (as delineated in the Statement on the Financial Requirements of Health Care Institutions and Services).

3. The health care institution's proposal should be reviewed, negotiated, and approved by the rate review agency on the basis of the community's need for the services and the associated financial requirements presented for the next fiscal period with due consideration given to significant unbudgeted gains or losses from the previous period.

4. Capital expansion and major modernization proposals of facilities and services should be reviewed and recommended for approval by the designated areawide health planning agency prior to the rate review agency's approval of the inclusion of these expenditures in a health care institution's prospective rates.

5. Health care institutions and the rate review agency should be able to request interim changes in rates or adjustments to future rates when major events occur which were unpredictable or were uncontrollable by the institution, such as but not limited to significant wage changes resulting from labor negotiations or major changes in occupancy.

6. An appropriate appeal mechanism for all parties should be established conforming to the substance of the procedures described in the Statement on Financial Requirements.

7. In each institution, equity calls for equal charges to all purchasers of health care for equal services received through the use of a single determined prospective rate for a unit of service. The most equitable method of determining the rates charged by the health care institution to all purchasers can be achieved by relating the specific rates to the specific services performed. However, other methods of measurement may be utilized on an experimental or demonstration basis in various parts of the country.

In addition, the following examples of prospective methods of payment are suggested as some of the possible alternatives. In any one of the examples the method of price justification or rate review may be organized as: (1) a public utility commission with rate setting powers granted by state law; (2) a voluntary board or committee made up of equal representatives of providers, contracting agencies, and the public; or (3) rate determination through direct negotiation between contracting agencies and providers. Any one of these price justification methods is applicable to the following other examples:

1. *Modified controlled charges.*—Prospectively determined charges approved for individual services for each institution. A charge related to operating expenses is determined by taking current operating cost, adjusted for changes in future prices and wages as measured by selected indices. In addition, rates applicable to non-operating financial requirements, such as capital, bad debts, and charity losses, and education and research, should be reviewed and approved for each individual institution based upon its needs according to the principles set forth in the Statement on Financial Requirements.

2. *Gross budget apportionment.*—A proposed budget for the period is prepared by each individual institution and submitted for approval. Each contractor pays a previously agreed upon percentage of the gross budget or a percentage related to actual services provided.

3. *Rates by hospital classification.*—Hospitals are classified according to scope of service, utilization, geographic location, size, etc. Prospectively determined rates for operating expenses are established for each class of hospital. In addition, rates for non-operating financial requirements are established for the individual institution's needs through a rate justification process.

4. *Capitation.*—For those institutions offering both hospital and and medical services, a single prospectively determined rate is established per person cared for per year. Prices are based upon the financial requirements of the organization providing these total hospital and medical services.

To accomplish the objectives of the *Statement on the Financial Requirements*, we make the following recommendation:

RECOMMENDATION

That section 1861 (v) (1) be amended under the definition of reasonable costs as follows:

1. Delete clause (A) of the fourth sentence of such section and substitute therefor the following: "(A) take into account both direct and indirect costs of providers of services, provided, however, that the costs of new construction or expansion and the cost of providing new services shall not be included unless such new construction, expansion, or new service shall have been approved in advance by the designated area-wide planning agency."

2. "The term 'reasonable cost' as used in this law shall mean the total monetary resources that a health care institution or service needs or will need to fulfill its role in meeting community health service objectives. The federal government's share of these financial requirements for its beneficiaries shall not be more than nor less than the share borne by all other paying patients."

The report suggests that payment for care be equated on the basis of institutions providing comparable services. We would point out that such an approach will require substantial increased administration and will, therefore be costly in itself. It would be necessary to certify in each individual case the comparability of patient care, and the relative efficiencies permitted by the institutions concerned. A system of prospective reimbursement such as we have recommended would be more likely to obtain assurance as to reasonableness of the costs incurred.

Reimbursement of Costs Under Medicaid

The staff report suggests a departure from the present practice of reimbursing hospitals under Title 19 on the same basis as they are reimbursed under Title 18. Legal counsel of the Administration has reiterated at various times that both Titles contain the same words "reasonable costs" and that it is impossible to interpret them differently. Their conclusion has always been that the basis for reimbursement *must* be the same under Titles 18 and 19 as enacted.

It must be obvious to everyone that any reduction in medicaid payments to hospitals or failure to reimburse hospitals fully for the cost of care provided medicaid beneficiaries will increase the hospitals' charges for care to all other patients. This is a result the public is not willing or able to accept. Further, the Administration has testified before this Committee that it does not accept such an approch.

It has seemed to us that the objective of the Congress in enacting Title 19 was to assure a system of equity in the provision of health services as between those patients who are able to pay and those who are not, with the further worthwhile end of assuring one system of health care in the country and not two. If the Congress is to attain this national objective it will be necessary for the Congress and the States to provide a system of financing that will enable hospitals to provide the needed care and services.

We therefore recommend:

RECOMMENDATION

If there is any doubt as to the requirement for full reimbursement to hospitals for care provided to medicaid beneficiaries, we urge the law be amended to make this requirement absolutely clear.

Bad Debt Collection

The report indicates the staff has developed evidence of failure of hospitals to devote sufficient efforts to collection of the deductibles. We know of no such instances. On the other hand, we believe there is a great deal of evidence that hospitals by their insistence on receiving payment of deductibles and copayment sums have incurred a great amount of ill-will from aged persons and their families who appear to be without any understanding that they are required under the law to make such payments. The onus and bad public relations resulting are borne by hospitals. We believe it is totally unjustified to require hospitals to bear the brunt of a requirement imposed by the federal government.

The determination of deductibles constitutes a most serious problem for hospitals. The determination as to whether the patient should be required to pay the deductible or whether it has already been paid in connection with another hospitalization or medical service is almost impossible, and particularly so with elderly persons. In order to satisfy itself that the deductible has not been previously used, the hospital must communicate with the Social Security Administration. This is time consuming, costly, and often cannot be accomplished within a reasonable period of time. The situation is even worse in the outpatient area.

We therefore recommend:

RECOMMENDATION

That deductibles be eliminated and that in their place the principle of coinsurance be applied to become effective at a specified point in an inpatient stay. The same principle should also be applied to outpatient services.

With respect to bad debts in general, they constitute a cost of operating a hospital. We do not condone any lax policy or failure on the part of hospitals to follow-up in respect to their accounts receivable and we believe that, in general, hospitals are greatly concerned with this problem. However, it must be realized what a difficult problem it is. The very nature of a hospital's activity does result, despite all its good efforts, in some bad debts which are in fact a legitimate cost of the hospital in meeting community needs. It is our position that the medicare program should participate as other purchasers of care do in the total cost of bad debts. This matter is another example of a critical problem which the Association has pointed out—the failure of the medicare and medicaid programs to participate fully in the community costs of hospitals.

Depreciation Allowances

The Committee staff report recognizes the need of accelerated depreciation in instances where approved capital needs cannot otherwise be met. We believe such accelerated depreciation should be authorized to institutions meeting the following criteria:

A. Expansion or major modernization projects should have areawide health planning agency approval; and

B. The financing of these approved projects entails the use of debt capital with amortization schedules shorter than the project's useful depreciation life.

Under the existing reimbursement formula, historical cost depreciation is the only recognition of an institution's plant capital needs. With respect to financed plant assets, however, the estimated life of the asset used in computing depreciation is almost invariably significantly longer than the duration of the debt retirement. Consequently, funds under straight-line depreciation are inadequate to make the principal payments. The only basis for amortizing these debts under the current formula is through the use of accelerated depreciation. In February of this year the Administration proposed the elimination of accelerated depreciation.

A great many hospitals are faced with commitments for debt retirement which cannot be fulfilled without extreme hardship if the original promises of accelerated depreciation under the medicare program are discontinued. These commitments were made in all good faith.

We therefore recommend:

RECOMMENDATION

That the use of accelerated depreciation be authorized in the legislation under the criteria set forth above.

Tax Exempt Status of Community Hospitals and Obligations To Provide Charitable Care (4)

We are attaching hereto (Appendix A) a copy of the Association's testimony presented to the House Ways and Means Committee on this matter. It is our position that requiring a nonprofit hospital to provide some free patient care in order to be tax exempt is unjustified, and the struggle of the Internal Revenue Service in attempting to articulate a reasonable guideline for application of the exemption indicates that the requirement is unworkable. The tests that should be applied in determining whether a hospital is exempt are whether it is operated principally to provide hospital care and whether any earnings of the hospital inure to private persons. Once it is shown that the hospital's earnings do not

inure to the benefit of any individual, the hospital should be exempt. The mere existence of the facility provides a basic service that would otherwise have to be provided by government.

Educational institutions, college football games, symphonies and jazz festivals are exempted from federal income taxes. Their exemption is not measured by the degree to which they provide free services. Surely a hospital is as essential to the public welfare as any of the above mentioned endeavors and a hospital's tax exemption should not be measured by the degree to which it renders free care, but rather on the basis that it is an available community resource and performs a public function.

Further, elimination of the tax exemption for hospitals would eliminate any hope of future donations by the public to health care and completely obliterate one of the last vestiges of encouraging and preserving private initiative in good works.

We therefore, strongly oppose the recommendation of the staff that Revenue ruling 69-945 be revoked, and we firmly believe that our position is totally in the public's interest.

We recommend:

RECOMMENDATION

That Section 501(c)(3) of the Internal Revenue Code be amended to provide a specific exemption from taxation for nonprofit hospitals.

Payment for Physicians' Services (5)

We firmly support all efforts by the government to eliminate abuse or fraud on the part of any provider of services.

We are well aware of the numerous efforts of the Congress and the Administration to assure the reasonableness of the "reasonable costs" reimbursement to institutions under the medicare program. We believe it is incumbent upon the Congress and the Administration to exercise equal concern as to the reasonableness of the "reasonable charges" used as a basis for paying physicians for their services.

In part, the difficulties in the operation of Part B of the medicare program are built into it by the legislation itself—the way it is presently structured with separate programming for care and services provided by institutions and for services provided by physicians. The present approach appears all the more incongruous when it is realized that the principal way in which institutional services under Part A can be utilized is through physicians' services provided for under Part B.

We see little justification for treating the need of aged persons for hospital care differently from their need for physicians' services. When we look at the annual incomes of large numbers of the over 65 and realize that in order to have protection against the costs of physicians' services under Part B, an aged couple must now pay $96 a year (and will have to pay $127.20 starting July 1, of this year), it is difficult to justify. The fact that approximately one million of the aged have not joined the Part B program is evidence that the cost of doing so is for many of them prohibitive. There would appear to be merit in providing for the working population to prepay the cost of physicians' services during their working years just as they now make prepayment for institutional health care services so as to be assured of such services upon reaching retirement.

The present separation of the program into two parts is cumbersome and wasteful in terms of administrative costs. The current requirements in respect to establishing Part B eligibility, the enrollment periods, and the procedures for increasing premiums resulting from late enrollment are a source of much confusion. The present procedures for relating hospital costs under Part A and physician charges under Part B are disruptive and costly.

It is noted that the Administration is proposing the establishment of a new Part C to the program. We have not seen any specific language for accomplishing this. However, when we view the difficulties that exist in administering the present two parts, we become greatly concerned about the establishment of yet a third part which could not but further increase both the administrative difficulties and the administrative costs of the program. Since the Congress is extremely concerned at the costs of the present program, surely the Congress will want to see much greater evidence provided that the addition of the proposed Part C will not result in a sizeable increase in the cost

of services to those beneficiaries who choose this approach to receiving health services.

We are strongly in favor of the health field moving towards a goal of "comprehensive care". There is at present, however, little agreement as to what this term means or includes. We feel that rather than adding a new section to the law, such an approach to the provision of health services could be authorized under a combination of Parts A and B, and made effective if and when it can be supported financially.

Combining Parts A and B into a single program would facilitate the understanding which aged persons have of the benefits to which they are entitled and would at the same time simplify and make less expensive the administration of the program.

We therefore recommend:

RECOMMENDATION

That Parts A and B of Title 18 of the Social Security Act be combined in a single program to provide institutional health care services and physician services.

That the Social Security tax structure be amended so that future beneficiaries will be able to prepay the cost of physician services in exactly the same manner as they presently prepay the cost of institutional health care services.

Further, that the definition of patient services in the existing law be made less restrictive so as to permit multiphasic screening, physical examinations and other preventive procedures for beneficiaries.

Also, should Congress decide to provide comprehensive health services to medicare beneficiaries, that this be done under a combination of Parts A and B of the existing law, rather than through establishment of a new Part C.

Payments to "Supervisory" Physicians in Teaching Hospitals (6) and Large Payments to Health Care Practitioners (7)

We believe that the law should provide for the payment of all physicians' services rendered to beneficiaries. We further believe that the government should take whatever steps are necessary to prevent any abuse in payments for physicians' services.

Incentive Reimbursement Methods (8)

The Association and numerous hospitals throughout the country have been earnestly working at the development of incentive reimbursement programs which can be documented to have meaning and which are administratively feasible. A committee of the Association is devoting itself to this task and we are very hopeful that some guidance to the field will result from these efforts. We do not as yet have any programs we can specifically recommend which may be used as a basis of providing "rewards". We look forward with interest to studying the recommendations which your Committee staff has indicated it is developing in this regard.

Attached hereto (Appendix B) are reprints of a number of articles which give some examples of what hospitals throughout the country are doing to utilize the latest and most effective equipment and means of providing services, and to bring about changes that will maximize the administrative potential for accomplishing these desired goals. Among the articles is one entitled "Innovations in Hospital Management" which summarizes 10 case studies conducted by the American Hospital Association and jointly sponsored by the Department of Health, Education and Welfare. The Association is continuing its efforts in exploring new and innovative methods and procedures to reduce costs wherever possible or to contain them reasonably and at the moment we are negotiating an agreement with the Department of Health, Education and Welfare for an updating and expansion of the 10 case studies covered in the article to which we have just referred.

It should be recognized that although there are areas of hospital operation where modern technology can be and is being utilized fully, there are definite limitations in this regard because the best in hospital care represents the best in personal human services.

Also, study and analysis of hospitals and their operation indicate clearly that the economic and efficient use of a community's health facilities depends on physicians. To accomplish the most efficient use of hospital facilities, it will undoubtedly be necessary that the medical staffs, trustees and administrators of hospitals develop programs which require physicians to reorient their practices. This will necessarily involve changes in the organization of physician services.

Certification of Extended Care Facilities (9)

Some of the difficulties that have been encountered result from the fact that extended care facilities did not exist or were not organized in many parts of the country at the time the medicare program was started. Under pressure of circumstances the Administration certified many nursing homes as extended care facilities. The American Hospital Association believes that an extended care facility is an extension of an acute general hospital and that the necessary services can be provided patients in such facilities only if the extended care facility is a part of or is located in close proximity to a general hospital. Otherwise the necessary degree of medical care and nursing care are not likely to be available. Many hospitals have now provided extended care facilities and information which we have received from the field indicates that if the necessary financial assistance were available many more would do so.

There are increasing reports, however, that extended care facilities are not being utilized or are being under-utilized in various parts of the country. This apparently is due in part, to the Administration's recent actions rejecting payment for large numbers of patients certified by physicians as being eligible for care in extended care facilities. We are further told that this has led to longer stays in acute general hospital beds for some patients. A thorough review and analysis of the present situation and ways of ameliorating it are urgently needed.

Institutional Utilization Review Mechanisms (11)

We believe that the process of utilization review is beginning to show real results in controlling the utilization of hospital facilities. The procedure is generally being developed so as to apply to all patients and not just to those who are the responsibility of the federal government. In some institutions utilization review has brought about a marked improvement in the use of facilities. The most recent data compiled by the research staff of the Association shows that since January 1, 1968, there has been a gradual reduction in the average length of stay of aged patients in general hospitals throughout the country. We believe this is to some extent attributable to the growing effectiveness of utilization review.

Much needs to be done to improve and strengthen the utilization review process. We have a group at work outlining procedures which they think will accomplish such improvements and which we then intend to urge upon the hospital field. This group is aware that a particular problem exists in rural areas and in smaller hospitals.

In our appearance before the House Ways and Means Committee last October we stressed that reports from around the country indicate that the effective functioning of utilization review committees is hampered because of the concern of physicians serving on such committees as to their personal legal liability. The Social Security Administration continues to point out that the function of utilization review committees is only to determine any future responsibility of the government for the payment of care, and not to force the discharge of patients. This simply begs the question. The utilization review mechanism is of primary importance to the financing of the medicare program and should be improved.

We therefore recommend:

RECOMMENDATION

That the federal government study the matter of the personal legal liability of physicians serving on utilization review committees and adopt such steps as are necessary to remove the concern of physicians in this regard.

Medicare Fiscal Intermediaries and Medicare Carriers (12 and 13)

We believe that the fiscal intermediaries have performed a most important task in behalf of the medicare program and everyone concerned with that program. Without the experience and machinery of the intermediary organizations it is unlikely that the medicare program would ever have "gotten off the ground". It was an enormous advantage to have such organizations available through which the providers of services could work so that the fears they had of such a federal program could be ameliorated. The intermediaries were already serving more than 60 million members of the public and it was possible to utilize the knowledge, personnel, and skills of these organizations to the great benefit of the program and public. In fulfilling the responsibilities assigned to them, the intermediaries have demonstrated their independence and objectivity.

We recognize that the government has a responsibility to obtain assurances as to the capabilities and effectiveness of the intermediary organizations. The staff report, after discussing intermediary selection and performance, recommends that "in order to avoid the types of problems discussed above, consideration should be given to authorizing the Secretary of HEW to designate intermediaries under Part A as he now selects carriers under Part B."

We find this to be a most amazing recommendation in light of the following statement which appears under Item 13 of the report: "Carrier performance under medicare Part B has in the majority of instances been erratic, inefficient, costly and inconsistent with congressional intent." (Part B carriers are selected by the government.)

We therefore recommend:

RECOMMENDATION

That the providers of institutional health care services continue to be given the right to select their fiscal intermediaries.

Quality of Administration of Medicare (14)

As we have already stated, the excessive administrative costs involved in accounting and auditing "overkill" and in the detailed procedures of the present program ought to be eliminated. The hospital field has from the inception of the program felt that certain of the information they are required to supply is meaningless and that compiling and submitting multitudinous reports has added unnecessarily to the complexities and the cost of operation of the program. Improvements and simplification in reimbursement such as a prospective rate formula would alleviate much of the existing aduiting overkill and burdensome detailed procedures, and would eliminate literay tons of the paper work now required of providers and of the government. It sounds rather simple to those administering the program in Washington to request a volume of detailed information which research people would like to have. It is our observation that there is insufficient appreciation of what such demands mean to the providers of services in terms of additional personnel and additional administrative costs. We wholeheartedly agree with the intent of the fourth suggestion in this section of the staff report that everyone concerned "should be relieved of as much data gathering and report making as possible . . ."

Medicaid Administration (15)

As we view the overall operation of the medicaid program, we believe many of its difficulties stem from the fact that there was a rather complete underestimation of the likely impact of the program and the size of the administrative job that would be entailed. When one realizes that the medicaid program potentially may involve twice as many beneficiaries as are covered under the medicare program, then the administrative machinery established for the medicaid program appears grossly inadequate. The problem is given further emphasis when it is realized that the total dollar volume of the medicaid program, which has nowhere reached its potential, is now approaching the cost of medicare.

State hospital associations throughout the nation work closely with official State agencies in the operation of the medicaid program. They have indicated in a recent survey that one of the major problems facing the medicaid program is the ineffectiveness of the advisory bodies established by the States. These advisory groups are in many cases not composed of the sort of representation that appears to be essential to fulfill their advisory role and often do not function in a manner that contributes to the continuing development and improvement of the programs at the State level. Frequently they are simply used as rubber stamps for State officials. Much more effective and stringent federal standards are needed to assure the proper use of State advisory bodies in the administration of the medicaid program in the States.

We continue to feel that health programs for the indigent and medically indigent should be run by health agencies and not by welfare agencies. Very different philosophies and skills are required for administering health programs as contrasted to welfare programs. Because of their experience, proposals have been made to utilize the machinery of voluntary health insurance organizations to handle the overall administration of medicaid. In fact Blue Cross plans are involved in the administration of the medicaid program in a number of States. An advantage of this is that it gives the government a way of knowing exactly and in advance what the cost of the program will be for a given period of time.

The challenge to the government is to establish a program which will meet

the health needs of the poor. These needs will not be lessened by the government simply deciding to spend less money than is necessary to meet them. If the government establishes a program that provides a maximum of 5 days of hospital care, who helps the poor person who needs to spend 14 days in the hospital? This would simply mean that the government is expecting somebody else to take over the responsibility and the hard fact is that there simply are no "somebody elses" left.

The recommendation of the staff to the effect that the advisory body under medicare should be combined with that of medicaid has great appeal but we feel the problems facing the medicaid program are of such magnitude and are in need of such extensive effort and advice that a combination of the advisory bodies would be unwise at this time.

Other Areas (16)

The combining of health facilities under a central administration can be very desirable and such group operation of facilities is being developed in many areas of the country by nonprofit sponsors as well as by forprofit sponsors. It is believed that such coordinated efforts give great promise for the future in their ability to provide comprehensive programs of care, to facilitate the most effective use of services and facilities within the group, to ease the transfer of patients as their needs demand from one facility to another, and to provide the various economies and other benefits of a central administration. However, we believe that no health institution, proprietary or nonprofit, should be permitted to construct or operate a health facility or service which is not deemed to be essential in a given area and the need for which has not been certified by an appropriate planning body. We hear of private entrepreneurs developing health care institutions where no need has been established or even in some instances, contrary to the findings and recommendations of planning bodies. We are in complete agreement with the staff recommendations that are aimed at avoiding abuse and manipulative potential by individuals or organizations interested only in investment in health facilities for the purpose of taking a quick profit and who are not interested in operating the facilities to meet the needs of the public. Such abuse should not be condoned.

In our opinion there are only two basic questions involved in the establishment of a health care facility. First, will the facility meet a definite community need, and second, will it be operated in a manner that will provide quality care as economically as possible. The Internal Revenue Service has indicated that numbers of instances have been revealed involving the transfer of ownership with inflated goodwill for the purpose of maximizing profits and taking advantage of the tax laws. We would urge that the Congress take whatever steps are necessary to support the Internal Revenue Service's efforts to eliminate such abuses.

Mr. Chairman, this concludes our comments on the staff report. We now wish to offer some additional recommendations on behalf of the Association and will then turn to other matters of concern to your Committee, to the public and to the hospital field.

OTHER RECOMMENDATIONS OF THE AMERICAN HOSPITAL ASSOCIATION

We have for some time been concerned at the inability of hospitals under the law to appeal from determinations made by the Social Security Administration or the intermediary on medicare reimbursement matters. We, therefore, recommend that an appeal mechanism be established to review such determinations.

RECOMMENDATION

In Section 1861 (v)(1) delete "and" before clause (B) and at the end of clause (B) add the following: "and (C)—provide for the establishment in each of the several states, including the District of Columbia, Puerto Rico and the Virgin Islands, of an independent appeals board comprised of seven disinterested third parties selected as follows: two by the providers of services; two by the Secretary; and three neutral members selected by such parties."

Spell of Illness

The spell of illness concept presently embodied in the law appears in Section 1861(a). The administration of inpatient benefits in accordance with the law and its interpretations entails excessive administrative costs that are inevitable under such a complex provision of benefits. There is little likelihood inpatient

benefits based on the spell of illness concept as defined and interpreted could ever be administered with equity for all beneficiaries or at a reasonable administrative cost.

RECOMMENDATION

That Section 1861 (a) be amended so as to eliminate the spell of illness concept and to provide instead authoriation for a specified number of days or inpatient care per calendar year to be used at that institutional level required by the medical needs of the patient.

Using the formula of the present law, this would provide 90 days of inpatient hospital care, 100 days of extended care and 100 days of home health visits to each beneficiary under the program in each calendar year.

Post-Hospital Extended Care Services

At present the law requires a person to be an inpatient in a hospital for not less than three consecutive days before he is eligible for care in an extended care facility as a medicare patient. The law clearly intends that extended care be an actual extension of hospital services. As we have stated, we concur with this policy.

We believe elimination of the three-day requirement would remove the present assurance that an adequate medical judgment has been made as to the necessity for care in an extended care facility. Lacking such a determination, the Government would lose an essential control over the administration of the program.

RECOMMENDATION

That as an alternative to the three-day inpatient requirement, the law be amended to authorize admission to an extended care facility if the patient has had a medical workup in the outpatient department of a hospital and following such workup his admission is recommended by the utilization committee.

Coverage for All Over 65

At the present time the law limits medicare coverage to those persons who are eligible to receive cash benefits under the Social Security program and Railroad Retirement beneficiaries. Thus, a group of the elderly continue to be deprived of the benefits of the medicare program. We believe that many of these elderly are especially in need of such protection. Inasmuch as medicare is a social program, we feel it should be amended so as to encompass all persons over 65.

RECOMMENDATION

That the medicare program be broadened to cover all persons over 65.

Reimbursement to Extended Care Facilities

At the present time the law provides that hospitals will be reimbursed on the basis of reasonable costs. This provision does not apply to extended care services and skilled nursing home care. The law provides for the services of extended care facilities, and we feel that the providers of such services should be assured of receiving essential reimbursement.

RECOMMENDATION

That reimbursement for services provided in extended care facilities and in skilled nursing homes be made on the basis of reasonable costs.

HOSPITAL COSTS

We know that this Committee is greatly concerned about hospital costs and what the future holds in terms of such costs. We share this concern. There are, of course, numerous factors in hospital costs which are completely beyond the control of the hospital. The nature of hospital care has changed dramatically in keeping with the explosion in science and technology. The variety and kinds of services offered by hospitals have expanded steadily. The vastly increased use of hospitals in this "new day" in medicine has changed the types of facilities and equipment needed and it has increased the numbers and skills of personnel required. The greatly changed role of the physician has also substantially increased the responsibilities placed upon hospitals.

Because of the significance of this whole matter, we are attaching as Appendix C an in depth review prepared by the Association's Bureau of Research Services

which traces the development of hospital costs, the growth of expenditures, the changing nature of hospital care, the increase in hospital salaries, the increase in no-salary expenses, and the increasing use of community hospitals in relation to population changes. It also reflects the substantial increase in utilization of hospitals by persons 65 and over.

The study concludes with projections of patient days and expenses through the year 1973. We wish we could assure this Committee that hospital costs will not continue to increase. However, this is certainly not the case. The study projects the expenditures per hospital patient per day in 1973 will reach $119.50; that the total days of hospital care will increase to 251.7 million; and that the total expenditures of these hospitals will approach $32 billion in the year 1973. As the study indicates "The pattern of rapidly rising hospital expenses over recent years can be expected to continue into the 1970's."

HEALTH COST EFFECTIVENESS AMENDMENTS OF 1969

These amendments were submitted by the Administration to the Congress and are we assume still pending before your Committee. As far as we know specific legislation incorporating these proposals of the Administration has not been introduced.

1. The proposal would provide that where a State agency or comprehensive planning group determines that any capital expenditure does not conform to the over-all plan for health facilities, the federal government will withhold or reduce reimbursement for depreciation, interest and return on investment related to such expenditure.

We have previously stated our full support of planning and recommended an amendment which provides that reimbursement agencies will be guided by the recommendations of planning organizations in determining the reimbursement to be made to health care facilities, provided assurances are given that the full financial requirements of the health care facility will be met.

2. The proposal would require as a condition of participation in the medicare program that provider institutions have written plans with respect to proposed operating expenses and capital expenditures.

The Association's *Statement on the Financial Requirements* recognizes that health care institutions have the responsibility of providing a plan delineating their future programs of health service to the people of the community and that the plan should be reviewed regularly with the designated areawide health planning agency to assure consonance of institutional and community health objectives.

However, there will be great uncertainty as to what is intended by a written plan for proposed operating expenses. Is this intended to give the government authority to dictate the operations of hospitals? It appears to us that this provision may well be in conflict with the declared purpose of the Congress in Section 1801 of Title 18 which expressly provides that the government will "not exercise any supervision or control over the practice of medicine or over operation or administration of medical facilities."

3. The proposal provides for more flexibility in the authority of the Secretary to develop and engage in incentive reimbursement experiments and demonstration projects. We wholeheartedly support the desirability of such experiments and demonstrations.

We do not believe, however, that the onus of establishing "hardship" should be placed on providers of services, as the Administration proposes, in order for them to escape mandatory participation in such experiments and demonstration projects. Furthermore, if as many as 20 percent of the health care institutions in an area feel a proposed reimbursement experiment or demonstration project is undesirable, this raises serious questions as to the possible success of the project.

Since the present law does not authorize continued reimbursement to providers of care on a basis that has been demonstrated as desirable and advantageous, we offer the following recommendation.

RECOMMENDATION

That the law be amended so as to authorize the Secretary to adjust the reimbursement formula on a continuing basis where experiments in methods of reimbursement are found advantageous and where both the providers of services and the Social Security Administration are in agreement as to such continuation.

4. The proposal would provide authority to bar further payments for services where there is evidence of fraud and other abuses. We are in complete agreement that the government should eliminate from participation institutions or individuals who engage in such practices. We believe, however, that the law at present gives the government authority to discontinue participation agreements with institutional providers of services. Apparently, the law does not provide sufficient authority to the government to eliminate from participation individual practitioners who engage in such abuses.

5. The proposal would provide authority to limit reimbursement to a facility's customary charges if such charges are less than costs. As a matter of principle we believe the charges for institutional care should reflect the full financial requirements of providing such care. We believe that no provider of care should expect to receive greater reimbursement than the customary charges for the care provided. Similarly, no purchaser of care should pay less than the customary charges.

6. The proposal would broaden the provisions of the present law with regard to decisions made by utilization review committees. We have already expressed our strong support of the utilization review process and have recommended actions to be taken by the federal government in order to make more effective the functioning of such committees.

We are concerned that the amendment recommended by the Administration in regard to "withholding payments where utilization review finds admission is not warranted" could be interpreted to mean the payments will not be made for services provided a patient who was admitted in good faith if, at a later time, a utilization review committee determines the admission and treatment were not warranted. We strongly oppose hospitals being left "holding the bag." Hospitals admit patients on the advice of physicians and must be protected from later determinations that the physician's decision was in error. The retroactive penalty proposed would, without doubt, cause hospitals to alter their admission policies.

7. The proposal would expand the authority of the Secretary to withhold further payments to a provider of services in order to recoup over-payments made to the provider. The law at present permits the government to offset over-payments against current bills, and we have no objection to this provision.

However, we understand the current proposal would allow the Secretary to estimate the amount of *presumed* over-payments for past periods of time and to offset such *presumed* amounts from the hospital's current reimbursements. We see no justification for such a provision. Certainly over-payments must be clearly established by proper accounting procedures. We find this provision most unjust in light of the extended delays by the Social Security Administration in making final settlements and payments to hospitals for services rendered to medicare beneficiaries.

We greatly appreciate the opportunity of presenting these views of the American Hospital Association to the Committee. We will be glad to answer any questions or furnish any additional information which will be helpful to the Committee in its deliberations.

APPENDIX

The Expenditures and Utilization of Community Hospitals: 1949–1968

Bureau of Research Services, American Hospital Association

At the present time, there is serious concern among many individuals and groups about the delivery of health services to the American people and about the costs of those services. The administrators and directors of hospitals, employee-employer groups that finance health services from earnings, the program administrators that seek to finance services for the aged and the medically indigent, and the legislators that must find the necessary funds for these activities have all become acutely aware of this problem. The objective of this paper is to review the development of present programs and concerns, to set these more recent trends in the context of the historical evolution of the modern hospital, and to examine the major factors contributing to cost increases in the health industry. On the basis of this review, a forecast of costs of hospital care will be made.

Before turning to the factors accounting for the recent growth in hospital costs, it is necessary to look at the evolution of the present-day hospital in order to understand the current organization and traditions of the industry.

The structure and organization of the modern hospital is rooted in the hospitals of 18th and 19th century Europe, especially Great Britain. In this early period, hospitals were used only by the poor who had no other place to go. Those who could remained in their homes and received treatment from their physician there, and this attitude is understandable in view of the state of medical technology and asepsis during the period—only one in three hospital patients was discharged alive.

The first hospitals were reflections of a social concern for the poor and the homeless, not the outgrowth of medical science. These voluntary hospitals tended to accept only conditions thought to be treatable in a short-term sense and cases of tuberculosis and mental illness were sent to public institutions (asylums) to keep them from contact with the public. Public institutions provided little medical care and were maintenance oriented. At this time, physicians donated their services since only the poor were treated in hospitals. Each hospital had a board of trustees and this group was active in securing the necessary funds for the operation of the institution.

As medical science advanced, hospitals gradually became centers of healing and physicians began to admit their private patients to perform procedures that could not be performed in the home. The use of the hospital for the treatment of private patients caused no change in the administrative-medical staff dichtomy observed in most community hospitals in the United States today. At this early period, the hospital provided primarily hotel services and nursing care and the physician could periodically visit the patient for diagnostic and therapeutic purposes. Few medical services were provided by the hospital.

In the decades since this original structure emerged, medical science has undergone a knowledge explosion and the nature of hospital services has changed radically. The extraordinary growth of science and technology in American society during the last three decades has irrevocably changed the nature of health services. The education and practice patterns of the physician document the impact of the knowledge explosion. Only three decades ago, nearly every physician was a general practitioner, with only a handful of men limiting their practice to surgery. By 1967, less than a third of the physicians in the United States were in general practice and less than ten per cent of current medical school graduates enter general practices. Specialization is now the norm for both practitioners and students—reflecting the fact that no man can presently hope to be both competent and current in more than a limited segment of medicine.

As the nature of medical practice has changed, so has the role of the hospital. The hospital is now expected to provide a wide range of services, ranging from intensive coronary care units through premature nurseries to specialized outpatient clinics for kidney dialysis. Nursing is still the core service of hospitals, but the nature of nursing services has changed almost as radically as that of the physician. An increasing proportion of nurses complete a four-year baccalaureate program and a growing number specialize in the delivery of health care in special intensive care units or assist in surgical procedures.

These basic nursing services are supplemented by a large number of ancillary services reflecting the complexity of medical science—electroencephalography, isotope laboratories, cytology, inhalation therapy, physical therapy, occupational therapy, therapeutic radiology, and cobalt therapy. These services are necessary adjuncts to the delivery of medical care and the physician's practice is increasingly oriented toward the hospital.

While the nature of hospital care has undergone dramatic changes, the relationship of the physician to the hospital and the organizational structure of the hospital itself have undergone little change during recent decades. The board of trustees is still responsible for the overall direction of the institution and the boards of most voluntary hospitals are self-perpetuating. Thus, the charity orientation of earlier decades frequently persists despite the fact that the overwhelming proportion of hospital revenue comes from patient payments. The medical staff is organized into a largely self-governing group, limited only by the overall policy guidance of the board of trustees. The daily operations of the hospital are controlled by an administrator who is hired by and responsible to the board. The administrator controls most of the departments of the hospital, but there are some exceptions in the areas of radiology and pathology. For these services, hospitals have made a variety of arrangements with radiologists and pathologists, including direct salary, lease, percentage of net revenues, percentage

of gross charges, and various combinations. In some institutions, the hospital allows the radiologist and/or pathologist to operate the department and bill the patients on a fee-for-service basis. In short, the organizational structure of voluntary hospitals has not changed dramatically in recent decades, and the separation of some departments from the regular administrative control has further fragmented the financial base of the institution.

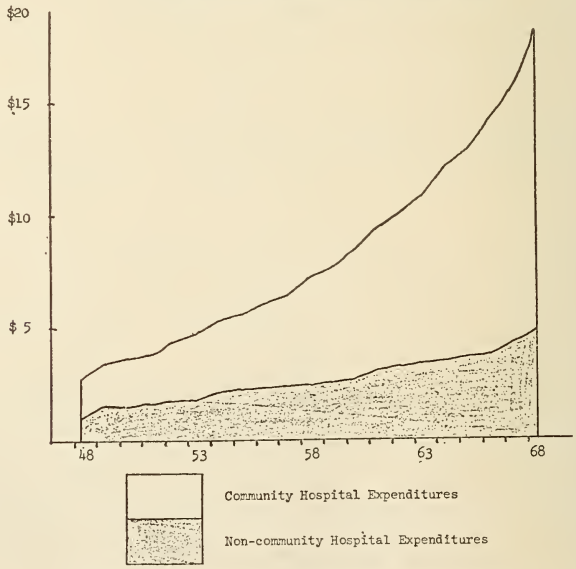
THE GROWTH OF HOSPITAL EXPENDITURES

The aggregate expenditures of the nation's hospitals have been expanding rapidly during the last two decades. In 1948, hospitals expended $3.5 billion and twenty years later the expenditures of the industry was $19.1 billion (see Figure 1). The overwhelming proportion of this increase occurred in community hospitals [1] rather than in long-term institutions. Between 1949 and 1968, the proportion of total hospital expenditures accounted for by community hospitals increased from 52.8 per cent to 74.3 per cent. Further, community hospitals are most frequently used by Medicare and Medicaid participants and have become the center of attention. For these reasons, this analysis will concentrate on the expenses and services related to community hospitals.

The total hospital expense per patient day is the most widely used measure of the expense per unit of output, and the expense per patient day for community hospital increased from $14.33 in 1949 to $61.38 in 1968 [2] (see Figure 2). While part of this dramatic change reflects the inflation inherent in current dollars, there is still a substantial increase in terms of constant dollars. In constant dollars, the expense per patient day increased from $15.62 in 1949 to $50.77 (see Figure 3). From these data, it is apparent that there has been a major increase in hospital expense for a day of inpatient care. It is the objective of this section to outline some of the major factors behind this increase.

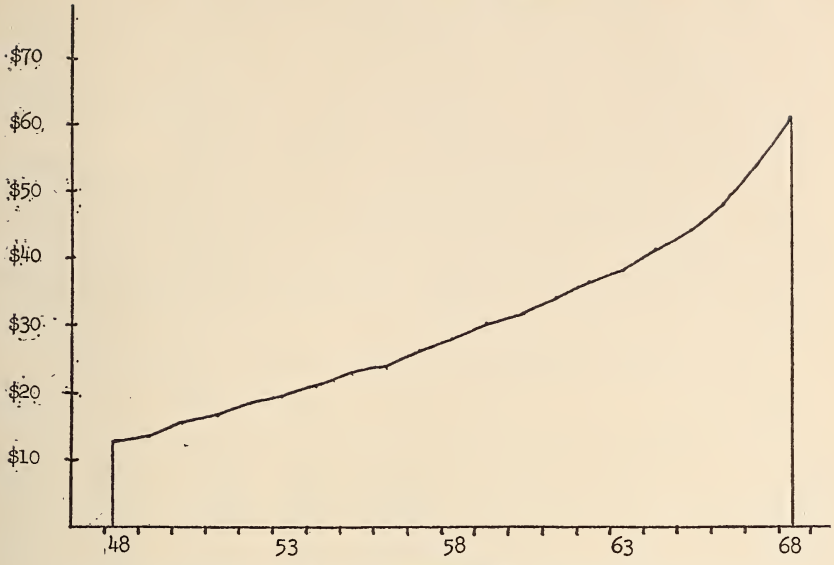
[1] Community hospitals are nonfederal, short-term general and special hospitals.
[2] All data used in this analysis come from the AHA Annual Survey of Hospitals unless otherwise noted. These data are published annually in the Guide Issue of HOSPITALS, J.A.H.A.

TOTAL AND NON-COMMUNITY HOSPITAL EXPENDITURES.



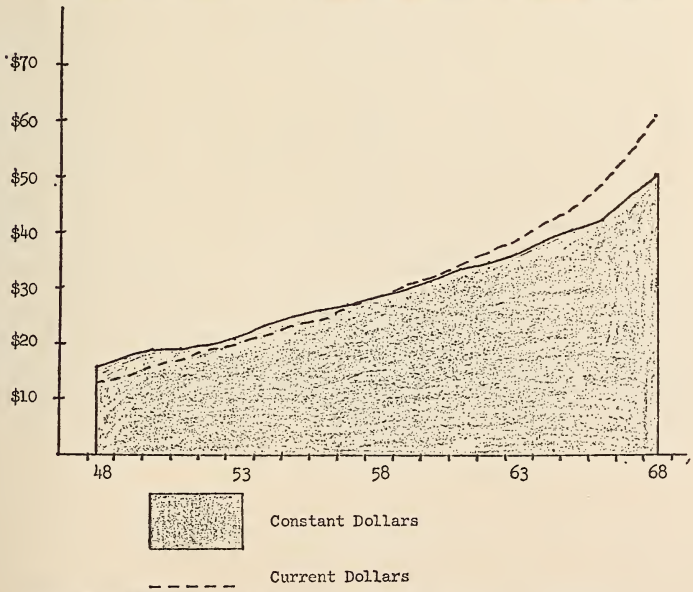
Source: HOSPITALS, J.A.H.A., (Guide Issue), August 1, 1949-1969.

EXPENSE PER PATIENT DAY IN COMMUNITY HOSPITALS



Source: HOSPITALS, J.A.H.A. (Guide Issue), August 1, 1949-1969.

EXPENSE PER PATIENT DAY IN COMMUNITY HOSPITALS IN CONSTANT DOLLARS



Source: HOSPITALS, J.A.H.A. (Guide Issue), August 1, 1949-1969.

In evaluating these data, it is necessary to note that there are significant differences among community hospitals in the level of expense per patient day. In general, larger hospitals have had higher expenses per patient day than smaller institutions and the magnitude of this difference has increased sharply during the last two decades (see Table 2). The factors contributing to the differences among hospitals are the same ones that have led to the general rise in expense per patient day noted above—the changing nature of hospital services, higher staffing levels, and more costly manpower. A separate examination of each of these factors will illustrate their impact on community hospitals.

The Changing Nature of Hospital Care.—Fundamental to an understanding of changes in hospital expenses per patient day is the recognition that the nature of hospital care has undergone major changes in the last two decades. Medicine has experienced a knowledge explosion and this is reflected in the services provided by community hospitals. As the diagnosis and treatment of disease has become more scientific and more complex, the physician must rely more and more on support services provided by hospitals and other groups. In short, a day of hospital care in 1968 was radically different from a day of inpatient care in 1949.

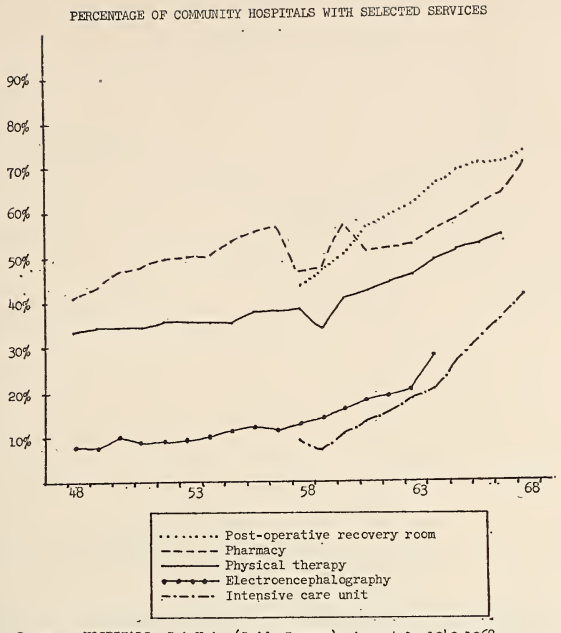
TABLE 1.—EXPENSE PER PATIENT-DAY FOR COMMUNITY HOSPITALS, BY HOSPITAL SIZE

Hospital size	1948	1953	1958	1963	1968
6 to 24	11.52	17.22	23.89	32.45	46.31
25 to 49		17.47	24.27	33.25	46.42
50 to 99	12.13	18.68	25.61	34.85	49.17
100 to 199	12.96	20.14	27.84	37.31	55.21
200 to 299	13.84	21.92	29.76	40.67	62.29
300 to 399		20.91	30.23	41.10	65.51
400 to 499				41.28	65.82
500 plus		19.01	28.82	41.45	74.03
Total	13.09	19.95	28.27	38.91	61.38

Source: "Hospitals, J.A.H.A. (guide issue), Aug. 1, 1949–69.

The scope of services provided by hospitals illustrates the impact of expanding medical knowledge. Hospitals today routinely provide a wide variety of procedures and services that were little known only a decade ago and certainly unknown two decades ago. Special post-operative recovery rooms and intensive coronary monitoring systems illustrate the new aspects of medicine in which the hospital is expected to provide services. Between 1949 and 1968, the percentage of hospitals with the services of a registered pharmacist increased from 41.3 per cent to 71.7 per cent. Similar patterns can be observed for post-operative recovery rooms, physical therapy, intensive care units, and electroencephalography.

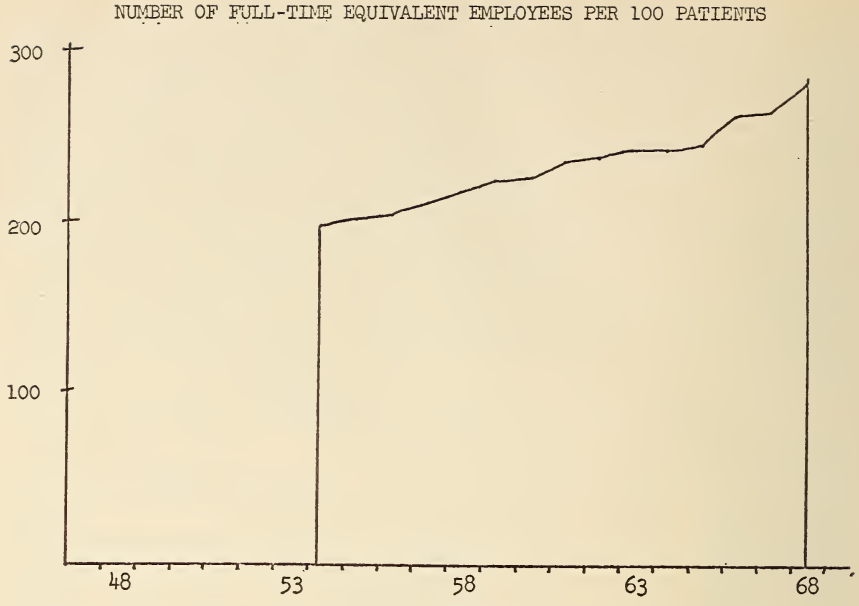
In addition to the expanding scope of services, many of the services offered by hospitals are becoming more complex. In the area of laboratory services, for example, hospitals have routinely provided tests of blood and similar materials, but with the expansion of medical knowledge it is now possible to obtain more information from these media than in previous periods. The laboratory is now subdivided into separate sections for hematology, serology, parasitology, cytology, and biochemistry. In each of these areas, an increasing amount of automation is being introduced—assuring higher accuracy and greater speed. Viewed in terms of expense, however, these new methods require more expensive equipment and more highly trained manpower, thus expenses related to the provision of these services are likely to be higher.



Source: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1968.

In the areas of billing and record keeping, hospitals have experienced substantial workload and cost increases during the last two decades. In early decades, the hospital business office was responsible for billing the patient, his insurance company, or a governmental agency for the cost of the services received and these were relatively simple. Now, reflecting the wider range of services available, the patient's record and his billing must be gathered from numerous different points within the hospital and maintained in a manner consistent with the reimbursement requirements of different insurance companies, Medicare intermediaries, state and local Medicaid offices, and other payors. Studies conducted by the American Hospital Association indicate that administrative and general manhours increased by 15 per cent during the first year of the Medicare program. While this aspect of hospital work has benefited from automation to an extent comparable to most other segments of American industry, the automation has not been able to offset the increases in workload and the expenses related to this activity have increased during the last two decades.

Consequently, the staffing of these new and more complex services has required a larger number of employees in community hospitals. Between 1954 and 1968, the number of full-time employees per 100 patients increased from 198 to 272 (see Figure 5). The most substantial jumps have come in recent years and similar patterns can be observed in the pattern of expense per patient day, suggesting a close relationship between the two factors.



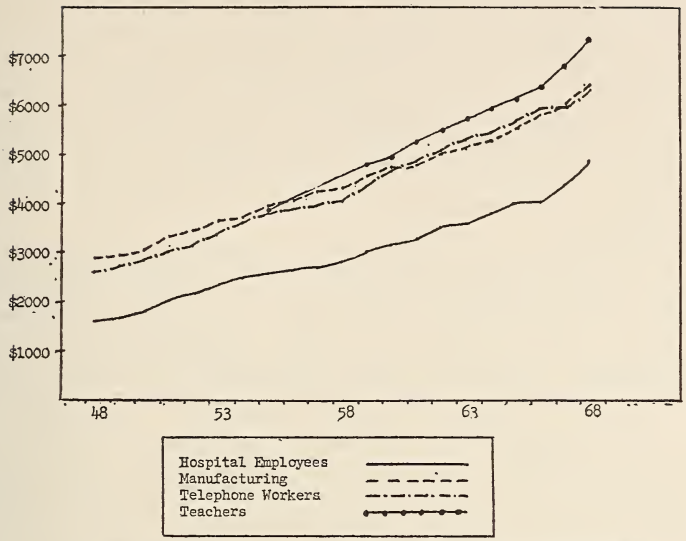
Source: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1969.

In summary, the growth of medical knowledge has had a substantial impact upon the nature of hospital care in the last two decades. Services previously performed in a physician's office have grown more complex and are now provided by specialized personnel in community hospitals. Services that were unknown two decades ago are now nearly routine in community hospitals. These changes have necessitated staffing increases and higher payrolls are reflected in the raising expense per patient day.

The Rise of Hospital Salaries.—The expenditures of community hospitals for the salaries of their staff have increased steadily throughout the last two decades and the rate of increase is rising as hospitals require larger numbers of employees with more training. In 1949, the average hospital salary was $1,715, but by 1968 the average annual salary had risen to $4,918. Viewed in relation to the annual salaries of other industries, it appears that hospital workers remain significantly below other groups (see Figure 6). It is appropriate to compare hospitals with both manufacturing and telephone services since all employ a wide variety of skills. In fact, the statistical information for manufacturing and telephone workers excludes supervisory personnel, thus the mixture of hospital staff probably includes a larger proportion of individuals with college or other advanced training. In view of the larger proportion of hospital employees with completed college training, a comparison of hospital salaries with those of teachers serves to indicate the probable direction of hospital salaries in the years ahead.

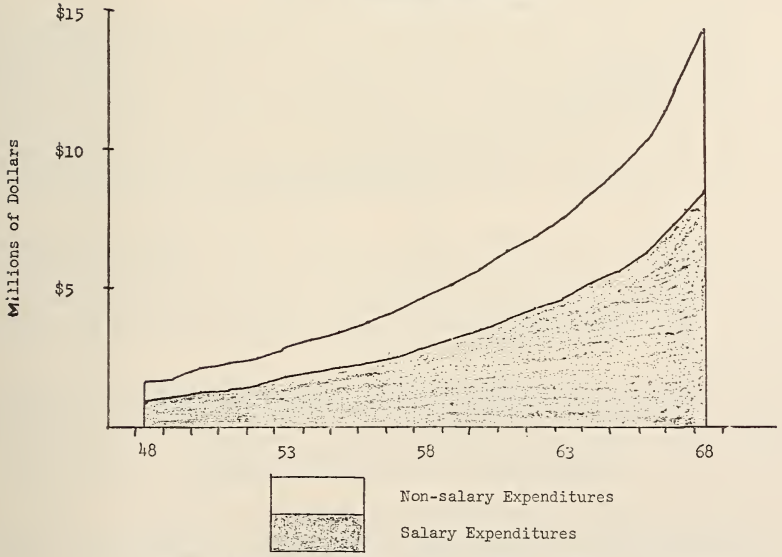
The Rise of Non-Salary Expenses.—In the last two decades, community hospitals have experienced a substantial increase in non-salary expenditures. While hospitals continue to direct approximately 60 per cent of their total expenditures into salaries, the non-salary expenditures have kept pace with payroll increases (see Figure 7).

AVERAGE ANNUAL SALARY FOR EMPLOYEES IN COMMUNITY HOSPITALS
AND SELECTED OTHER INDUSTRIES



Sources: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1969, and Office of the President, ECONOMIC REPORT OF THE PRESIDENT, 1969.

SALARY AND NON-SALARY EXPENDITURES
OF COMMUNITY HOSPITALS



Source: HOSPITALS, J.A.H.A., (Guide Issue), August 1, 1949-1969.

The major factors in this rise are the broader range of supplies and equipment hospitals must purchase and the rising prices of these goods and services. Hospitals must purchase a large number of items—ranging from computer equipment and/or services to raw foodstuffs. Further, the price of some of the scientific equipment required by hospitals today has been increasing at a rate higher than the Consumer Price Index. In short, hospitals are also consumers and the general inflation of recent years is reflected in their non-salary expenditures.

Professional fees paid to physicians are included in non-salary expenditures,[3] and increases in physician fees and salaries in recent years have contributed to the overall rise in this category. Since hospitals must have these services, the severe shortage of physicians has led to large increases in this area. Further, many hospitals are finding it desirable to employ full-time directors for the major medical-surgical services and this causes further increases in the level of non-salary expenditures.

It is also necessary to note at this point a measurement change that accounts for some of the increase in non-salary expenditures. As hospitals have moved from a basically charity orientation toward a modern business organization, the sophistication of their accounting and financial management has grown accordingly. In the last decade, hospitals have more consistently maintained a separate capital budget and recorded their depreciation. The extensive financial reporting requirements of the Social Security Administration have served to expedite this process, increasing the accuracy of depreciation reporting. Since depreciation is a part of the hospital's non-salary expenditures, some of the increase observed may be attributed to better financial reporting.

The Growth of Ambulatory Care.—The extraordinary and continuing expansion of hospital services to ambulatory patients is important in understanding the rise in expense per patient day. The basic problem lies in the expense per patient day statistic itself. This statistic is derived by dividing the total expenditures of the hospital (for all the services provided) by the number of days of inpatient care. In short, the numerator includes expenses related to the delivery of outpatient services but the denominator does not contain comparable service units. This distortion was relatively unimportant in earlier years when a much smaller volume of hospital services were provided to outpatients, but the rapid growth of outpatient services in the last two decades has created special problems for the interpretation of the expense per patient day statistic.

One solution is to convert the number of outpatient visits into equal work units roughly equal to a day of inpatient care. A formula using inpatient and outpatient revenue has been developed to produce a new statistic called *adjusted patient days*. When total expenses are divided by the number of adjusted patient days, the result reflects more accurately the actual expenses related to a day of inpatient care. Since the necessary calculations have been done only from 1963 to the present, comparisons cannot be made for the full 20-year period used in this analysis. In 1963, the expense per patient day included $3.80 attributable to services for outpatients, and by 1968, it included $5.58 from this service (see Figure 8).

The Absence of an Incentive System.—A final factor important in understanding the increase of the expense per patient day is the absence of an effective incentive structure for hospital management. As noted in the earlier discussion of the development of the current organization of the hospital, most community hospitals lack a single point of administrative control and neither the administrator or the medical staff have any direct incentives to control hospital expenditures.

The major source of hospital revenue is patient payments and the great majority of these come through insurance and other prepayment plans or reimbursement programs that essentially pay on a cost-recovery basis. If the expense related to some services goes up, the hospital usually receives an increase in its payment or reimbursement. A reduction of expenses would simply lead to a reduction of revenue.

In a similar fashion, the physician bills his patients directly in most cases, and is neither rewarded nor penalized for the level of hospital expense. Desiring to practice the best medicine possible, physicians tend to encourage greater

[3] Since some hospitals compensate their staff physicians by direct salary, others on a percentage basis, physician fees are included in non-salary expenses to insure more uniform financial reporting.

hospital expenditures for equipment and expanded services. This is not to say that there are not many physicians who are conscious of costs and who try to control expenditures, but rather to point out that the incentives inherent in the system encourage the opposite behavior.

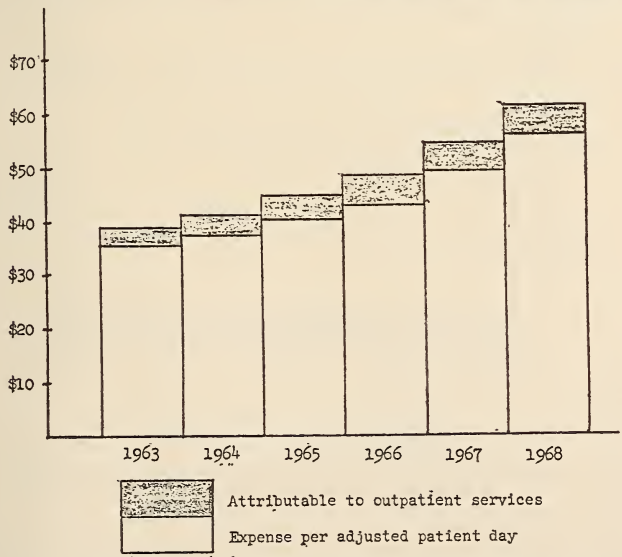
Finally, the structure of insurance and prepayment coverage today encourages inpatient utilization by excluding payment for ambulatory care. For the individual patient, it appears less expensive to use a day or two of inpatient care rather than incur the out-of-pocket expense related to an outpatient procedure. Since the hospital expenses make little difference to the physician, some admissions for inpatient services reflect the coverage of insurance plans rather than medical need. The problem resides with the structure of the system, not with the individuals involved.

Summary.—The nature of hospital care has undergone radical changes during the last two decades, reflecting the general knowledge explosion in science and technology. Hospitals have steadily expanded their services to include a wider variety of ancillary departments. More manpower has been required and higher salaries have been required to attract the necessary personnel. At the same time, the price of supplies and equipment purchased by hospitals has grown, reflecting the inflation of the economy in general.

The growth in the expense per patient day also reflects the increasing delivery of services on an ambulatory basis. Because of the nature of the measure itself, it tends to slightly overstate the real expenses attached to the delivery of a day of inpatient care.

Finally, the absence of effective incentives for the management and the medical staff of hospitals has contributed in part to the rise of expenses per patient day. Physicians are generally compensated by the patient directly and hospitals are reimbursed on the basis of the full cost of the services rendered in most instances. The payment structure of the industry at present does not contain positive incentives for effective cost control.

COMMUNITY HOSPITAL EXPENSE PER PATIENT DAY AND PER ADJUSTED PATIENT DAY

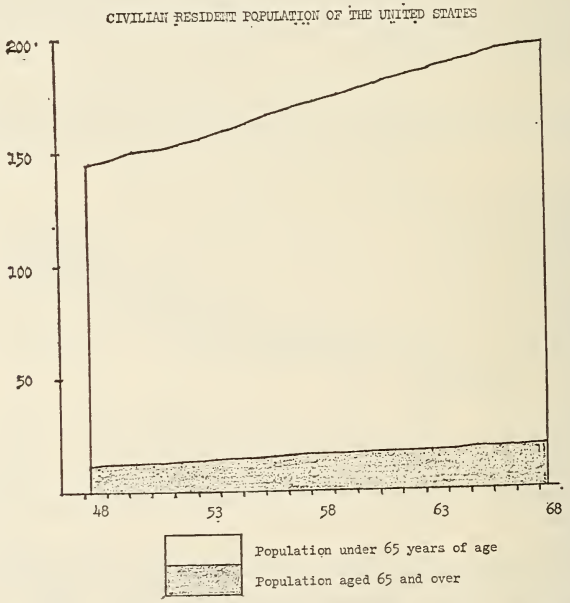


Sources: HOSPITALS, J.A.H.A. (Guide Issues), Aguust 1, 1964-1969, and "Hospital Indicators," published in HOSPITALS, J.A.H.A. monthly.

During the last two decades, the use of community hospitals has increased in both absolute and per capita terms. The preceding discussion outlines the major factors in the rise in expense per patient day, and it is the objective of this section to examine the past and present trends in the use of hospital services. The combination of the expense per unit of service and the number of services used is responsible for the total amount of the nation's resources devoted to hospital care.

Increases in utilization can be viewed in terms of the growth of the nation's population and the level of use per capita. The following analysis will examine both of these factors and the concluding section will review the utilization of community hospitals by persons aged 65-and-over after the introduction of Medicare.

Population Increases.—In the twenty-year period between 1949 and 1968, the civilian resident population of the United States increased by a third—from 148.2 million to 197.6 million (see Figure 9). The number of persons aged 65-and-over increased from 11.9 million to 19.1 million, and as a percentage of the total population the aged increased from 8.0 per cent to 9.7 per cent. In short, the total population of the nation has been rising steadily and the elderly portion of the population has been rising slightly more rapidly. If everyone used community hospitals in 1968 only as much as they used them in 1949, there would have been an increase in use of at least 33.3 per cent. but since the proportion of elderly is rising more rapidly and they generally use more hospital services than younger people, utilization might have been expected to increase even more.

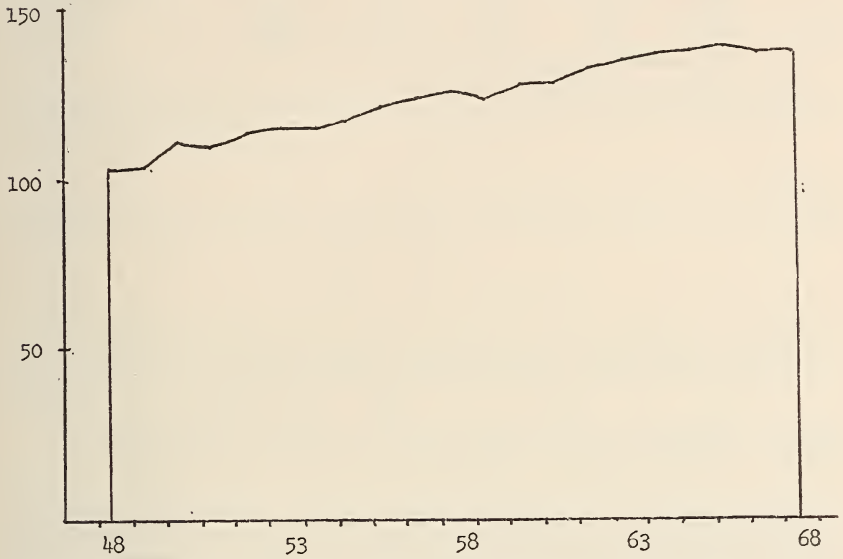


Source: U. S. Department of Commerce, STATISTICAL ABSTRACT OF THE UNITED STATES, 1969, and CURRENT POPULATION REPORTS.

The rate of community hospital utilization per capita has not remained stable during the last two decades, but rather has increased steadily. The number of admissions per 1000 resident population increased from 104 in 1949 to 138 in 1968—an increase of 32.7 per cent for the twenty year period (see Figure 10). While this increase is not dramatic in contrast to increases in expense per patient day, it does indicate a pattern of greater utilization per capita. The average length of stay in community hospitals declined in the 1950's and early 1960's, but in recent years the average length of stay has returned to almost

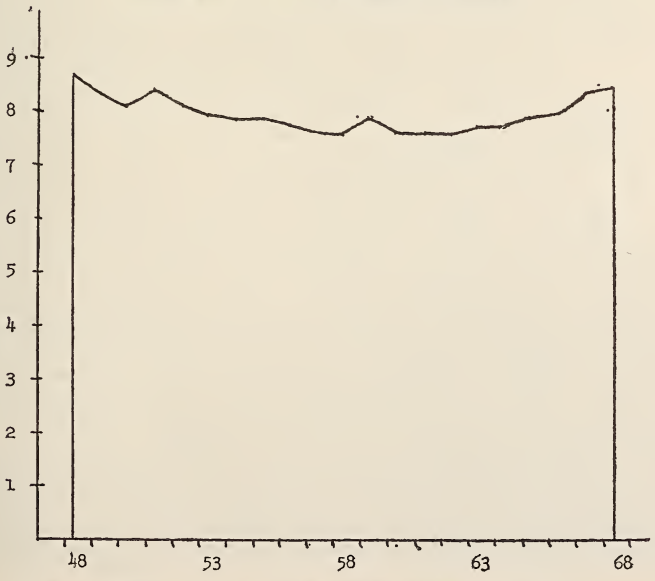
the 1949 level (see Figure 11). During the period of the declining length of stay, the shorter stay partially offset the increasing level of admissions, and this is reflected in the total number of days of inpatient care provided by community hospitals. For the 20-year period, the number of inpatient days per 1000 civilian resident population increased from 867 ot 1167 (see Figure 12).

NUMBER OF ADMISSIONS PER YEAR PER 1000 CIVILIAN POPULATION



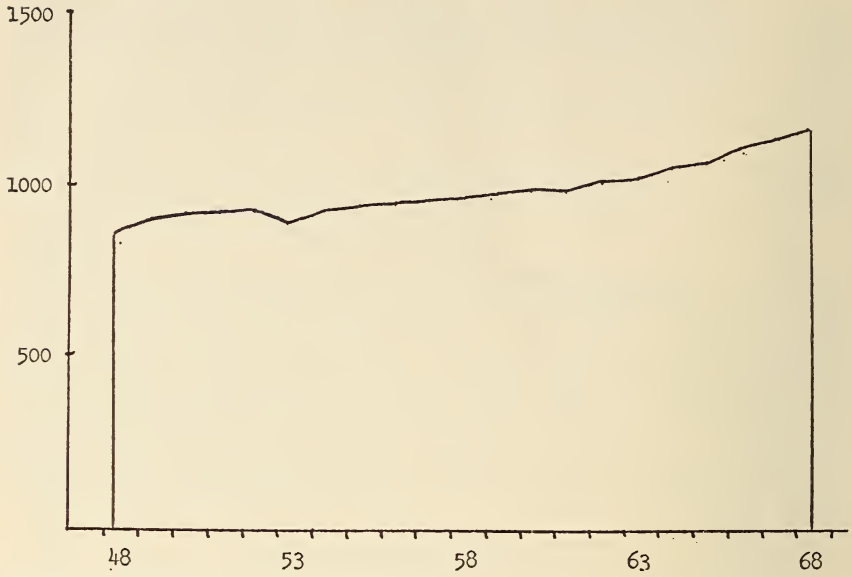
Source: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1969.

AVERAGE LENGTH OF STAY IN COMMUNITY HOSPITALS



Source: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1969.

NUMBER OF DAYS OF INPATIENT CARE PER YEAR PER 1000 CIVILIAN POPULATION



Source: HOSPITALS, J.A.H.A. (Guide Issues), August 1, 1949-1969.

When the increase in population and the growth in per capita use of community hospitals are combined, the full rate of increase in inpatient utilization is apparent. Between 1949 and 1968, the number of days of inpatient care increased from 128.5 million to 230.6 million—an increase of 79.5 per cent.

It is clear from these data that the use of community hospitals expanded significantly during the last two decades and the total expenditures of the hospital industry would have grown substantially from utilization increases even if the expenses per patient day had not risen.

The one aspect of community hospital utilization that has attracted the greatest public attention is the use of hospitals by Medicare beneficiaries. The recent increases in the overall length of stay and the number of days in inpatient care delivered have been widely attributed to utilization increases by elderly patients. On the basis of reports from the National Hospital Panel Survey for the first three and one-half year period of the program, it appears that hospital utilization by 65-and-over patients did increase at a high rate early in the program, but that the rate of increase is declining (see Table 2). The rate of increase in the number of admissions of elderly patients increased sharply during the first two and a half years of the program, but is declining slightly now. Presently, the number of admissions is still increasing approximately five per cent per year. The average length of stay increased slightly during the early part of the program, but it is now declining in absolute terms. The impact of the declining length of stay is apparent in the rate of increase in the number of days of inpatient care used by patients 65-and-over. In the last half of 1969, for example, the number of elderly admissions increased by 5.4 per cent and the average length of stay declined by 3.0 per cent, which limited the increase in the number of patient days to 1.9 per cent. The number of days of care is the best indicator of overall community hospital utilization and these data suggest that Medicare utilization is approaching or may have reached a plateau.

Summary.—As the population of the United States expands, more hospital services are consumed, and the civilian resident population grew by a third during the last two decades. In addition, the use of hospital services per capita has been advancing at nearly the same rate as population growth, thus actual utilization of community hospital increases by nearly 80 per cent between 1949 and 1968.

TABLE 2.—MEDICARE UTILIZATIQN

Period	65+ Adm.		65+ stay		65+ days	
	Number	Rate[1]	Days	Rate[1]	Number	Rate[1]
July 12, 1966	2,525		12.4		31,256	
Jan. 6, 1967	2,683		12.9		34,667	
July 12, 1967	2,654	5.1	13.1	5.6	34,886	11.6
Jan. 6, 1968	2,851	6.3	13.4	3.9	38,206	10.2
July 12, 1968	2,860	7.8	13.3	1.5	38,111	9.2
Jan. 6, 1969	3,043	6.7	13.1	−2.2	39,937	4.5
July 12, 1969	3,015	5.4	12.9	−3.0	38,841	1.9

[1] The rate is the percentage increase over the comparable time period in the prior year. By comparing the 1st 6 months of 1968 with the 1st half of 1967, a rate of increase can be obtained that excludes the seasonal variation in hospital use between the 1st and last 6 months of the year.

Source: "Hospital Indicators" published monthly in Hospitals, J.A.H.A.

Recent increases in overall utilization reflect higher utilization by Medicare recipients, but an analysis of these data indicates that the overall utilization by persons 65-and-over is reaching a plateau.

A REVIEW AND A FORECAST

In the previous sections, the analysis focused on the factors involved in the rise of expense per patient day and on the patterns of utilization experienced during the last two decades. This section will first project these trends from 1969 through 1973, then examine the projections in the context of the conclusions of the previous sections.

An analysis of the financial and utilization data for the period 1949–1968 indicates that most of the utilization patterns approximate a straight line increase, but that expenses evince a curvilinear pattern. Working from these findings, separate projections were made for hospital expenses and the number of days of inpatient care provided. A linear regression model was used to project the patient days and a polynomial regression was used to project total community hospital expenditures. The separate projections were used to estimate the expense per patient day for the period 1970–1973 (see Table 3).

On the basis of these projections, it appears that the expense per patient day will reach $119.50 in 1973. The projections also indicate that 251.7 million days of care will be provided by community hospitals in 1973 and that the total expenditures of these hospitals will approach $32 billion. The pattern of rapidly rising hospital expenses of recent years can be expected to continue into the 1970's.

TABLE 3.—PROJECTED EXPENSES AND PATIENT-DAYS, 1970–73

Year	Total expenses (millions)	Inpatient days (millions)	Expense per inpatient day
1970	19,159	234.5	81.66
1971	22,401	240.2	93.26
1972	26,051	245.9	105.94
1973	30,078	251.7	119.50

In examining the projected figures, the essential question is whether any of the conditions responsible for the recent pattern of expense increases are likely to change during the period for which the projection was made. A careful review of each of these factors reveals that few significant reductions can be expected and that even sharper increases might be expected in some areas.

The rapid advance of science and technology has had the most important impact on the hospital industry in recent years and there is no reason to believe that there will be any reduction in the output of research and development in future years. The general pattern for scientific discovery is that each new advance paves the way for other discoveries, thus accelerating the pace of innovation. Further, many of the medical advances of recent years are still limited to use in teaching and research centers and the federal government recently indicated a renewed effort to reduce the time between development and wide appli-

cation in this area. For these reasons, it is reasonable to expect the pace of scientific innovation in medicine to quicken rather than slow in the foreseeable future.

As medical science continues to advance, the scope of services offered in community hospitals will continue to expand and the complexity of hospital services will continue to grow. More manpower will be needed and higher educational achievements will be required. Viewed in comparative terms, hospital salaries are still lower than those of many other segments of American industry and there is no reason to believe that hospital workers will be content with less than parity in this regard. In short, the payroll expenditures of community hospitals can be expected to continue to increase at their current rate or perhaps an even higher one.

Finally, the population of the United States will continue to grow and the increased number of people will require more hospital services. While the specific rate of future population growth is uncertain, it is safe to assume that the pattern will be similar to that of recent years. Birth control and public consciousness of overpopulation may have a longer-run effect, but there is little chance that the pattern of population growth will change significantly during the 1970–1973 period.

The major opportunities for cost containment are in the areas of utilization, management, and planning. The data indicate that inpatient utilization increased steadily during the last two decades and that the special increases due to Medicare are running their course. It is unlikely that the rate of increase in the future will be greater than that in the past. Further, there is a possibility of reductions in inpatient utilization. A number of the major insurance carriers and prepayment organizations are considering revisions in their coverage structure to encourage greater utilization of outpatient services in place of inpatient care. It is unlikely that this sort of shift will have any significant impact during the period of these projections, but the longer-run effect could be important and should be noted.

Secondly, there are a number of experimental reimbursement and incentive plans now being operated and studied throughout the nation and it is reasonable to believe that more effective management systems can be designed for community hospitals. Most of these experiments are designed to extend over a period of years and it is too early to predict specific outcomes, but the recognition of the problem by hospitals and the federal government is an encouraging sign. Little impact can be expected in the short run, but this is a promising area for longer-run considerations.

Finally, more effective planning can help to control costs by eliminating duplication of facilities and personnel. In its "Statement on the Financial Requirements of Health Care Institutions and Services," The American Hospital Association has outlined a program to assist in cost control. But, as above, improved planning and coordination will have more impact in the long run than the short run.

On balance, it appears that the impact of scientific innovation will continue to be the primary factor in shaping health care and influencing its cost. Even if effective management incentive and facility planning programs were instituted today and if the basic structure of insurance coverage were revised immediately, it is unlikely that the savings realized would offset the increases in hospital expenses stemming from the development of medical science. This is not to argue against better management. Unquestionably, it is better to achieve the maximum management saving rather than add the cost of bad management to the expense of better science. The essential point is that management and planning alone cannot and should not be expected to alleviate the increase in expenses associated with the advance of medical science.

Senator Anderson. I think it is a very fine presentation. Thank you, gentlemen.

Senator Ribicoff?

Senator Ribicoff. Mr. Berke, president of the American Hospital Association, and Dr. Philip Lee, were recently quoted as saying that on a conservative basis, by 1980, hospital costs in rural areas would run $400 a day, $600 a day in urban areas, and as much as $1,000 a day in major urban centers.

Do you agree or disagree with these projections of your predecessor, Dr. Philip Lee, who is at HEW?

Mr. HAHN. I have not discussed with Mr. Berke this statement that he apparently made. I can conceive how, in certain cases, for certain types of certain days of care, this might be true. I would not personally agree, generally for all patients, on averaging it out at such a cost level. But again, I do not know the manner in which both Dr. Lee and Mr. Berke interpreted this.

We do point out a figure that we think hospital costs will reach in 1973.

Senator RIBICOFF. But it is apparent that the rise is going to be astronomical, no matter how you figure it. Do you think the economy, the individual, can possibly pay for such rising costs? And what do you think ought to be done to try to cap the fantastic rise in hospital costs in the United States?

Mr. HAHN. I think first, the hospital costs are affected by the same thing that other costs are, the inflationary process, which has to do with this.

I think primarily, we have a multiple effect because we deal in personal services, with a 2-to-1 ratio as compared to most industry, Therefore, when we raise personnel costs $1 a day, it costs 60 to 70 cents a day for our patients, whereas in industry, when they raise personnel costs $1 for a day, it affects it about 30 to 35 cents. So we have double the effect of any increased compensation to personnel that is normally true in the rest of the economy.

I think advances in health care and technology that have been magnificently implemented in hospitals have greatly improved mortality and greatly increase costs. As long as there is improved scientific techonology and advancement in medicine, the costs are going up regardless of what happens in inflation.

Senator RIBICOFF. How do you think it is possible for the public to absorb this? The rate of inflation in hospital costs is really double that in all other segments of society, taken as a whole. The individual, you would assume his wages and his earnings would be going up as normal inflationary pressures rise. But if hospital costs double the rate of inflation, how will the individual be able to pay for this increasing cost?

Mr. HAHN. The individual, we think, can pay for it only by leveling those costs throughout his lifetime and throughout all segments of society. Individually, he cannot do it at a specific spell of illness.

Senator RIBICOFF. So basically, you are going to have to come to that basis, according to the plan that Senator Fannin raised, or some other scheme or proposal of general insurance, one way or another, for a patient in a hospital?

Mr. HAHN. Medicare and medicaid took the 20 percent of patients who used health services at twice what the rest of the population used them. It took those people off the back of the health insurance companies, which has enabled them to keep up with the spiraling health care costs. In the future, other groups in society might need to be added, such as the disabled, to these programs, as Congress is certainly doing, looking at means of handling total health services for all the population.

Senator RIBICOFF. Now, Dr. Amos Johnson, past president of the American Academy of General Practice, with other eminent physicians, has testified that upward of 30 percent of hospital admissions

are not medically necessary. Do you agree with such a figure, that 30 percent of hospital admissions are not necessary?

Mr. Hahn. I do not agree with such a figure. I think there are unnecessary hospital admissions. I think that our insurance program has encouraged the utilization of a hospital for, often, services that could be provided on an ambulatory basis. I think we now find that 90 percent of our Blue Cross plans are providing some form of outpatient diagnostic services to encourage that this be done on an outpatient basis.

I think the building of extended-care facilities, from which we were boxed in by the financing mechanism in past years, is also a means of getting patients out of the hospital and using ambulatory self-care services and the extended-care service for people who don't still need horizontal bed care.

Senator Ribicoff. What we would like from the American Hospital Association, Mr. Chairman, I think, is a list of hardheaded recommendations of what they think could be written into the law and regulations to eliminate medically unnecessary hospital admissions and continued stays.

Would you undertake to do that for us?

Mr. Hahn. Yes; I would, sir.* I would also like to point out that we have a special committee composed of some very positive-thinking individuals who are meeting in behalf of the American Hospital Association, including well-informed hospital trustees, private practitioners of medicine, hospital-based physicians, some of the leading hospital administrators who are studying our policies regarding the delivery of health services.

We hope that later, by the end of this year, that committee will have come up with recommendations for the American Hospital Association to make, both to its member institutions and to other providers of health services and to the Congress, regarding changes we think can be made in the delivery system to make it both suitable and available, and hopefully, more economical.

Senator Ribicoff. Well, this becomes very important. I think, as Senator Williams has pointed out, time and time again, the runaway costs are placing the whole program and the fiscal solvency of the Government in jeopardy. The committee certainly would like these recommendations as soon as possible, because I think it becomes necessary to write them into the law and the regulations, as well as self-policing.

Now, is this study also going to talk about alternatives to expensive hospital care and how you bring these altogether into a chain?

Mr. Hahn. Mr. Williamson is serving as one of the secretaries of that committee. I would like to ask him to speak to that, Senator.

Mr. Williamson. Yes; it is, Senator. Those on the committee are thinking of an alternative to hospital beds, broader use of ambulatory care, community health centers which will relay patients to the hospital only as need be, and new ways to coordinate and make more effective the relationship of physicians and hospitals so that there is greater assurance that hospital facilities will be used as needed and only as needed. They are going into such matters in great depth.

*See AHA letter to the chairman, p. 421.

Senator Ribicoff. How are staff recommendations that planning agencies be broadly representative of all providers of health care in order to avoid emphasizing one type of care to the possible exclusion of less costly alternatives, how do you react to the staff recommendation as to such overall planning agencies?

Mr. Hahn. We thoroughly agree with that. We propose this in the formation of planning groups, and I think it is in our statement, the American Hospital Association statement on planning. We think it is the only appropriate way to set up such a group.

Senator Ribicoff. Can this be done voluntarily, or does it have to be in the law and regulations? Has any town yet tried to do this, any city in the United States?

Mr. Hahn. I think that most of our 314(b) agencies, which are the voluntary agencies, are made up in this manner.

Senator Ribicoff. But many are not. But basically, they are hospital dominated, are they not? I mean, are the hospitals not really the boss? You carry the clout, you carry the numerical weight?

Mr. Hahn. In the B agency, it must start out first with 51 percent of the people that have the consumer label.

Senator Ribicoff. You are talking about the areawide planning agency, are you not?

Mr. Hahn. Yes; I am talking about the areawide.

Senator Ribicoff. But you are not talking about an overall utilization committee representative of hospitals, extended care facilities, nursing homes; and the public, working together?

Mr. Hahn. This, we think, is the planning agency.

Mr. Stagl. I think we may be talking about two different things. Our concept is the planning of health services in an area.

Senator Ribicoff. I know that. But I am talking about the utilization, the proper utilization of facilities to bring down the cost. We must bring all agencies, all deliveries of service, of health care, together.

Mr. Hahn. I think a planning agency can do this from a standpoint of total utilization of facilities. I think when we are really talking about utilization, though, we are talking about an individual patient, and I think it is hard to get mulitple groups to look at an individual patient. When we look at the total concept, I think this falls within the purview of the planning agency, and utilization should be one of the things they look at as they plan for different types of services and facilities.

Senator Ribicoff. I have one other question, and I do not want to take up too much time of the committee, and I have some more after other members have questioned.

Do hospital utilization committees justify an average length of stay in maternity cases of 3 days in one section of the country and 10 days in another? Is there such a variable in sections of the country that under medicaid programs, a mother will be in the hospital for 3 days, in one hospital and in another hospital a mother may be there for 10 days?

How can this be justified?

Mr. Hahn. I think, first, that there are reasons to keep medicaid patients, obstetrical patients, in a hospital longer because of the kind of home situations that most such patients are discharged into. I think

there is very little justification for the average private patient in it. But there is reason for the medicaid patient. They often come in with no prenatal care, they are undernourished. It is a different kind of health problem than you get with a normal private obstetrics patient.

Senator RIBICOFF. Let us say I follow you on that. Do they have to stay in expensive hospital beds for the other 7 days? Could they not be transferred to an extended care facility or another type of care, or have home health service and advice from visiting nurses as to what you do with the baby the other week?

I mean, we are trying to take care of the actual services that people need and yet keep the costs down. Why an expensive hospital bed for an extra week?

Mr. HAHN. I think that in the average general hospital those patients are a very small percentage, and to provide another kind of facility or service would be difficult.

We also must meet State licensure standards for care of maternity patients. Therefore, you have to have appropriate maternity facilities and appropriate facilities for the newborn. But I think this is a small percentage.

Mr. STAGL. I think there is less economy than you might think in moving the mother to another kind of facility, because whatever you do, at least out our way, it has to be a segregated facility. It cannot be, you cannot move her into an extended care facility. You have to then set aside part of your extended care facility only for mothers.

Senator RIBICOFF. But I would suppose in a big city like New York, Chicago, Los Angeles, Detroit, the percentage of medicaid patients in the maternity sections of the hospital must be very, very large. It is not a rural area, where you might have one or two mothers giving birth under medicaid. I can see a rural area in Arizona, but now you switch to Phoenix.

Or I can see New York City or Chicago, as against some small town in upper New York State. So here you know how many children are being born in every given year, so you could plan that way, and you would have sections of extended care facilities for mothers for the next few weeks.

Mr. STAGL. I think you are assuming that the maternity, at least, in the regular hospital is the same cost as the surgical or medical patient. That is not so. They get a lesser amount of care. You are not as staffed on post partum as you are on the other floors.

Mr. HAHN. The post partum care is the least expensive care in the hospital and the least expensive part of obstetrics. From the second day on the obstetrical cost is the marginal cost. It is the empty beds you have that are the greatest percentage of obstetrical costs.

Senator RIBICOFF. I understand the Chicago Maternity Center, with the cooperation of four hospitals, is instituting a plan to discharge a mother within 1 day after the birth of a child and then have home care facilities for the mother, in her house.

Mr. STAGL. This happens to be our hospital.

Senator RIBICOFF. All right. Now, this is what we are trying to drive at. We are trying to bring some commonsense to it. Now, it is your hospital. Are you going to have a program to discharge a mother 1 day after the birth of a child?

You take that and you say, somebody is saving 9 days of hospital care. Why can you do that and why can we not have programs like that in other sections of the country?

Mr. Stagl. Well, to correct one assumption, we are combining several maternity hospitals plus the Chicago Maternity Center of Chicago, which has been delivering babies in the home for a good many years. The fact is that this is no longer either popular or medically acceptable, delivering in the home. So we are going to try to build—we still have to build this facility, this women's hospital. We are going to experiment and try it on the basis of delivering the woman in the hospital, and having her stay 24, maybe 48 hours.

This is strictly experimental at this time. If it works, if it is acceptable to the Chicago Board of Health, and if it is a proper medical procedure, with good results, I suspect you will find many, many hospitals grabbing it.

But there is at this moment no proof in the United States that this will be acceptable. We are going into it as an experimental kind of thing.

Senator Ribicoff. This leads me to something I raised before at these hearings. Would it be possible for the American Hospital Association to make some recommendations to authorize the Secretary of HEW to institute various private projects across this Nation, various methods and procedures to give good, more effective and less expensive hospital care and extended facilities?

In other words, we are trying to spend billions of dollars on a program which we do not know will work or not.

One of the tragedies of Government is we appropriate hundreds and hundreds of millions of dollars on programs and we never know whether they are going to work or not. I think maybe, we ought to start pulling in our horns a little bit and give the various Secretaries some authorizations for some pilot projects and let us try them out in the country before we try spending billions of dollars on the program.

Would you come up with some suggestions on what you think might be some pilot projects that might be worthy of consideration?*

Mr. Stagl. I think, Senator, we do not blow our horn loud enough. In the case of maternity, I know seven towns in Illinois where two hospitals which have traditionally been running maternity units have combined them into one unit. This makes a much more efficient setup.

I know there are hospitals in five or six big cities across the country which are now running laundries that take care of maybe 10 or 12 hospitals.

I know in Chicago they now have about 30 hospitals signed up in a central computer unit.

There is a great deal going on. Some of it is not going to be dramatic, big dollars, but it is an attempt to move toward this sort of thing.

To get into the medical area, I think it would be good to have help to try some of these things where they seem feasible.

Senator Ribicoff. Thank you, Mr. Chairman.

Senator Anderson. Senator Williams?

Senator Williams. I have no questions.

*See AHA letter to the chairman, p. 421.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. No questions, Mr. Chairman.

Senator ANDERSON. Senator Fannin?

Senator FANNIN. I was just wondering about the catastrophic illnesses that are involved. Do you have any statistics that would give us information on this? I am thinking about those individuals that are not covered by insurance, and have a catastrophic illness requiring hospitalization and often they are not in a position to pay, and thus, they do not stay the length of time necessary. This is always a worry that people have, that they will have a catastrophic illness situation to contend with. Are there any statistics in this regard?

Mr. HAHN. I think we have estimates on various kinds of catastrophic illnesses individually, such as chronic kidney disease, where areas of the country have been studied and then those figures transposed to cover the Nation. I think, in considering all catastrophic illnesses, I doubt if we have statistics.

But I think we could, in talking about tuberculosis or kidney disease and certain specific things, come up with some figures. I think insurance companies have some very good statistics on this.

Senator FANNIN. Very good. I shall try to get that from some insurance companies. The reason I asked is that we try to determine the need we have for coverage and whether we could have a program that would give coverage to these people who would be so involved.

Mr. HAHN. I think this would be the least expensive program because it is such a small number of people. But they need it so very badly.

Senator FANNIN. That is what I was trying to determine; thank you.

Senator ANDERSON. I would like to know about the commitment of the American Hospital Association to planning today and its vigorous opposition to the Anderson amendment in 1967 with respect to planning, which is, in essence, the provision in the House bill just approved.

Mr. HAHN. I will speak to it; then I would like Mr. Williamson also to comment, because I was not intimately involved at that time.

At that time we were not opposed to planning. As stated, we were very much for planning. But we thought that if you did not provide funds for programs that did not meet planning approval, funds should be provided for those that did need planning approval.

And because of the lack of recognition of one side of the coin, we could not agree to the recognition of the other side.

Senator ANDERSON. The Anderson amendment did include funds for planning.

Mr. HAHN. That funds be provided for approved capital projects?

Senator ANDERSON. No, sir; for the planning agency expenses. It is essentially the same provision as that in the House bill now—which the administration has endorsed. In essence, it is what you are talking about in the statement.

Mr. WILLIAMSON. What we are talking about, was that we were for planning. We said then, I believe, just as we are saying now, that hospitals have to have for their capital needs built into some planned program. It is difficult to tie their lifeline to planning controls unless they have full assurances to meet their economic needs. That is what we said then, and the bill at that time, the legislation did not provide those assurances. We are still saying they are needed now, and our proposal

hopefully will encourage the Government to go ahead so we can have planning more completely than we have it now.

Senator ANDERSON. In other words, you are opposed to planning without capital contribution?

Mr. WILLIAMSON. We need assurances on the overall financial requirements of the hospitals so that they do not have to dip into operating funds to meet their capital needs and so that they have assurances that their operating funds will be what is necessary and that there will be funds on a planned basis for their capital needs.

Mr. HAHN. We think the positive side of planning should be recognized as well as the negative side.

Senator RIBICOFF. Just one more comment. I note in the paper in the last few days stories about the complete disintegration of health programs and health policy in the Federal Government. This is in line with the reporting—the report issued by another committee of which I am a member, about the lack of national policy in the health field. There is no national policy and no coordination.

How does the American Hospital Association feel about the necessity of a President having a council of health advisers to coordinate all health activities in the Government and in this country?

Mr. WILLIAMSON. We have felt so, Senator, for a good many years since the Hoover Commission reports, which first enunciated that a Federal health council was greatly needed. We think the need is more evident now than ever before. There is no coordination of Federal health programs, and one hand of the Federal Government does not seem to know what the other hand is doing.

We have noted that the Federal Government is for planning for everybody else but the Federal Government. The Federal Government and its facilities do not participate in any way in community planning organizations. They want to be free of them to go their own way.

We think that there needs to be established a national health policy for the Nation, which we do not now have, and that such a council could lead us in a desirable direction.

Senator ANDERSON. Thank you, gentlemen.

(Pursuant to questions raised by the subcommittee of the previous witnesses, the following letter was received from the American Hospital Association:)

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., June 19, 1970.

Hon. CLINTON P. ANDERSON,
Chairman, Ad Hoc Subcommittee on Medicare and Medicaid, Senate Committee on Finance, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to questions asked and requests made by members of your Subcommittee during the course of testimony presented to the Subcommittee on May 26th by Mr. Jack A. L. Hahn, Mr. John Stagl and me on behalf of the American Hospital Association.

1. Mr. Hahn, President of the Methodist Hospital of Indiana, said in reply to a question asked by Senator Ribicoff, that the hospital he serves has rendered more charity services since the passage of medicare and medicaid than prior to that time and that the amount of such charity services being provided by his hospital now exceeds $1 million a year. Senator Anderson requested a statement on this be provided to the Committee. Below is a tabulation of charity services rendered by the Methodist Hospital of Indiana during the decade 1960–70.

"The following is an analysis of charity services rendered by Methodist Hospital during the 1960–70 decade. It does not include bad debts, employee, professional or courtesy discounts or discounts on contract services such as medicare. These figures have been audited by Ernst and Ernst.

"For the year ending:

"Dec. 31, 1960	$496, 433
"Dec. 31, 1961	602, 067
"Feb. 28, 1963 (14-month period due to change in fiscal year)	527, 553
"Feb. 29, 1964	547, 207
"Feb. 28, 1965	567, 704
"Feb. 28, 1966	715, 038
"Feb. 28, 1967	770, 309
"Feb. 29, 1968	889, 689
"Feb. 28, 1969	1, 246, 765
"Feb. 28, 1970	1, 293, 531

JACK A. L. HAHN."

2. Senator Ribicoff asked if we had available any data on the amount of money received by hospitals in charitable contributions and on the total amount of Federal, State and local grants to hospitals. The Association has not compiled any such figures. The most recent figures we have on national health expenditures are for the fiscal year 1969 and they come from a Department of Health, Education, and Welfare Publication, *Research and Statistics Note No. 18, 1969*, by Barbara Cooper. This publication shows the total expenditures in the U.S. during the fiscal year 1969 for hospital care were approximately $22.5 billion and that an additional $2.5 billion was spent for construction and modernization of health care facilities. Approximately 51% of the combined fiscal year 1969 expenditure of $25 billion for hospital care and construction or modernization of health care facilities came from the private sector, with philanthropy providing 10% ($2.3 billion). Of the $2.3 billion in philanthropy, $1.5 billion was for construction or modernization of facilities, and only $.8 billion was for patient care.

How much of the fiscal year 1969 expenditure of $22.5 billion for hospital care came from State and local sources and from philantrophy? The study shows that $4 billion came from State and local sources and, as stated above $.8 billion came from charitable sources. Adding these two figures gives a total of $4.8 billion which is 21% of the total hospital care expenditures in the U.S. for the fiscal year 1969. It should be recognized that practically all of the $4 billion from State and local sources represents care by municipal, county and state hospitals. We would also point out that the approximately $7.2 billion figure given in the report as the Federal Government's fiscal year 1969 expenditure for hospital care, was nearly all in the form of payment for services rendered medicare and medicaid beneficiaries, and is not in any sense a *grant* to hospitals.

3. Senator Fannin inquired whether the Association had yet made a detailed study of his bill, S. 2705, and Mr. Hahn replied that we have not. The Board of Trustees of the Association recently established a special committee to undertake a major evaluation of the Association's policies with regard to the quality of health care, the organization of physician and institutional health services, the role of fiscal intermediaries, and the means of financing health care. Among the issues being studied by this committee on the provision of health services are: What organizational changes should be introduced to provide more effective delivery of institutional and physician services? How the quality of such services can be evaluated. What kind of incentives and/or controls should be employed in the delivery of institutional health care? What are the most effective and economical approaches to the financing of patient care, medical care facilities construction and modernization, and the educational and research activities of health care institutions? The committee will later this year be reporting its recommendations to the Association's Board of Trustees and the Association has, therefore not developed conclusions with respect to S. 2705 and other proposals in the area of national health insurance.

4. Several of the members of the Subcommittee, especially Senator Ribicoff, engaged in a colloquy with the AHA representatives concerning the high cost of hospital care and what could be done about it. Specifically, Senator Ribicoff asked for any recommendations the Association could offer to be written into law or regulations to eliminate medically unnecessary hospital admissions and

continued stays. In our testimony, we pointed out that the most recent data compiled by the Association's research staff shows that since January 1968 there has been a gradual reduction in the average length of stay of aged patients in general hospitals throughout the country. This we believe is to some extent attributable to the growing effectiveness of utilization review. We have a group working on the development of procedures they think will accomplish improvements in utilization review which will then be urged upon the hospital field. Meantime, we have recommended that the Federal Government study the question of personal legal liability of physicians for decisions and actions of utilization review committees on which they serve, with the aim of removing the concern of physicians in this regard. If this is done, we are sure it will enable utilization review committees to function more effectively.

5. Finally, Senator Ribicoff expressed his great interest in the initiation of research and demonstration projects across the nation with regard to various methods and procedures aimed at bringing to the people of the nation good and more effective and less expensive health care, including hospital care, care in ECFs and ambulatory care. We would first reiterate that the health care delivery system should strive to replace high cost hospital care with less expensive care in ECFs and nursing homes to the extent that the medical needs of patients permit, and also to replace the latter types of care with ambulatory care or home health services to the maximum possible extent. This offers the most effective way to reduce the Nation's total health care costs. The goal stated in a monograph, "Outpatient Health Care" which was developed by the American Hospital Association in conjunction with the U.S. Public Health Service, is that the hospital of the future become an ambulatory care center with inpatient beds attached. Since outpatient care costs approximately ⅓ of the cost of an inpatient day, Federal support in the form of necessary start-up capital for these health care alternatives to inpatient hospital care, and full payment to providers for such services rendered to beneficiaries of all government health programs should bring substantial savings in overall health care expenditures.

We feel you will be pleased to know that the Association, through its Health Services Research Center at Northwestern University has applied to the National Center for Health Services Research and Development of the U.S. Department of Health, Education, and Welfare for grant support for the following projects, which it is hoped will point the way to significant reductions in hospital inpatient costs.

1. An evaluation of the effectiveness of a multi-hospital health care arrangement embracing rural, urban, and metropolitan populations.
2. The establishment of revolving funds to assist hospitals in conducting mergers with other health care institutions.
3. The development of hospital shared insurance programs.
4. The development of shared hospital laboratories.
5. The development of hospital materials delivery systems.
6. The development of specialized construction assistance for groups of hospitals.
7. The study of labor-saving capital equipment.

Other study projects have also been proposed which might eventually produce recommendations of additional ways hospitals could reduce costs. The interest and help of the members of your committee in the funding of the Association's Health Services Research Center grant applications would be greatly appreciated.

Planning is, of course, one of the indispensable keys to bringing good health care to the people of the nation at the lowest possible cost. We have not commented on planning in this letter because the Association's full support of comprehensive health planning, covering both facilities and services, is well-known to the Committee, and we feel our testimony at the hearing made clear that the Association continues to support proper planning.

Copies of this letter are being sent to each member of your Subcommittee. We hope it will be helpful to the Subcommittee. If the American Hospital Association can be of further assistance, please call on us.

Sincerely,

KENNETH WILLIAMSON,
Deputy Director.

Senator ANDERSON. The Federation of American Hospitals, Mr. Sherwin L. Memel, is our next witness.

STATEMENT OF SHERWIN L. MEMEL, VICE PRESIDENT, FEDERATION OF AMERICAN HOSPITALS; ACCOMPANIED BY SAM A. WEEMS, DIRECTOR, LEGISLATIVE BUREAU; AND MICHAEL BROMBERG, DIRECTOR, WASHINGTON BUREAU, FEDERATION OF AMERICAN HOSPITALS

Mr. MEMEL. Mr. Chairman, members of the subcommittee, I am Sherman L. Memel, vice president of the Federation of American Hospitals and chairman of its Bureau of Insurance Committee, as well as a recent appointee to HIBAC, the Health Insurance Benefits Advisory Council.

With me today is Mr. Sam A. Weems, to my right, director of the Federation's Legislative Bureau, and Mr. Michael Bromberg to my left, director of the Federation's Washington Bureau. I shall ask permission to submit the entire statement for the record and then to comment on portions of it.

Senator ANDERSON. That will be done. Thank you very much for doing that.

You may go ahead.

Mr. MEMEL. Thank you.

I might also mention at this time that I have the privilege of serving on two committees dealing with matters to which Senator Ribicoff has addressed himself. One of those committees is the committee of the Federation of American Hospitals, and the other is a committee referred to by Mr. Hahn and Mr. Williamson. I do have hope that we will have, before the end of the year, some constructive recommendations for alternatives to the present health system.

The Federation of American Hospitals is the national association of investor-owned—proprietary—hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations.

Our member institutions range from small rural facilities to the largest investor-owned comprehensive medical care complex in the Nation.

The Senate Finance Committee staff, in its report, has focused on a number of problem areas in the medicare and medicaid programs and we concur with many of the findings set forth in the committee staff report, "Medicare and Medicaid—Problems, Issues, and Alternatives."

Specifically, the Federation of American Hospitals agrees with the committee staff that utilization review has "generally speaking" been "ineffective as a curb to unnecessary use of institutional care and services," and we see a real need for meaningful and effective utilization review procedures for all levels of institution care.

Federation agrees with the committee staff that there have been "inordinate and protracted delays in final settlement and accounts" and we share their concern about high administrative costs and audit "overkill."

We concur that intermediary performance "varies widely" and we urge action to correct the lack of uniformity and timeliness in interpretations of the program regulations. We agree that more effective Internal Revenue Services reporting requirements covering payments

under the programs are needed and we communicated our support for such reporting requirements to the chairman of the Senate Finance Committee in July of 1969.

The investor-owned hospitals of America are committed to providing quality health care at reasonable cost and we believe that the free enterprise sector of the hospital field can make a significant contribution to the development of a more efficient and more effective delivery system. This can be done by stimulating competition and providing alternatives to the consumers of health care—all within the framework of a single system.

We believe that some of these proposals for constructive competition will be forwarded by the committees I have referred to previously, and also that the health maintenance organization concept, which is being presented by the administration and by the House bill, will be a move in that direction.

On page 6, the following recommendations are made by the Federation of American Hospitals with a view toward short-range improvements in the medicare-medicaid programs and also as basic ingredients in the development of a new health care delivery system which can in time meet the needs of all Americans.

PROSPECTIVE INCENTIVE REIMBURSEMENT

The Federation of American Hospitals supports a broad program of experimentation on a voluntary basis with a number of prospective rate formulas in order to determine which method would be most equitable to the providers and purchasers of hospital care.

I would like to mention at this time that we emphasize the word "experimentation," because we believe, as Senator Ribicoff indicated earlier, that perhaps the time has come for us to try on for size some of the things we propose to do instead of going for them full force and regretting afterward that we did not study them more carefully.

We note in chapter 8 of the committee staff report that an incentive reimbursement proposal is being drafted by the staff. We would welcome the opportunity to cooperate in the formulation of such a proposal.

Investor-owned hospitals have never been pleased with the mechanics of a retroactive cost reimbursement under medicare. The lack of predictability, time and expense of multiple audits and lack of incentives for developing new efficiencies are just some of the weaknesses inherent in any formula which simply pays for cost.

On the other hand, we would caution that the concept of prospective reimbursement or the use of a so-called negotiated rate is subject to literally hundreds of interpretations and variations, depending on what components are used to arrive at the prospective rate. Another problem in pinning down the details of a prospective rate formula with which we are struggling has been the question of the starting point or base from which the rate is to be derived.

A committee of Federation of American Hospitals, the Bureau of Health Insurance Liaison Committee, which I chair, has been meeting with the Social Security Administration during the past few months in an effort to develop a pilot program under the incentive

reimbursement authority of title XVIII. The basic features of our proposal include a rate based on the average costs of all hospitals in a locality, grouped under a classification system based on size and scope of services. A reasonable profit—either a fixed percentage or the difference between average charges and average costs in the locality—would be added to the base rate. Additionally, the rate would be tied to agreed upon indexes to reflect average cost increases. However, this total rate would be fixed and the provider would be required to absorb all costs in excess of that rate.

This type of prospective rate would provide the economic incentives to which the committee staff has referred. It would match hospitals of similar size and scope of services against a standard, encouraging competition with a goal of stabilizing hospital costs through a system of rewarding those institutions which provide quality care while operating below communitywide levels, thereby bringing down or at least containing costs in the locality.

Again, as I have mentioned earlier, we do endorse the concept of the health maintenance organization.

Turning to the bottom of page 9 of our comments on reasonable costs, the difficulties encountered by providers as well as those responsible for administering the medicare-medicaid programs are most troublesome in the area of determining reasonable costs. While a growing number of health officials now favor some form of prospective reimbursement as the ultimate solution to this problem, there remains a need under present reimbursement regulations to make the determination of reasonable cost more equitable. This program must be resolved swiftly and accounts finalized without further delay.

We support the proposed reimbursement for additional nursing costs for medicare patients. Studies have demonstrated the existence of these costs and we hope the promised adjustment will be implemented retroactive to July 1, 1969.

While we understand the mounting pressure for cost controls under medicare and medicaid, we cannot concur with arbitrary controls drafted with little concern for the economic plight of institutional providers, whose costs have soared largely as a result of increased labor costs, new equipment requirements and obsolescence.

In this regard, we do not support the committee staff recommendation—staff report, page 53—that accelerated depreciation be eliminated under medicare. The original purpose of these medicare regulations—to assist providers maintain sufficient cash flow to service their debts on assets, is more relevant today than it was in 1965. Some modifications may be needed to protect the program against overpayment in situations where assets are transferred without recovery by the Government of the excess of accelerated over straight-line depreciation.

In that event we believe the Government should be able to recapture the excess in a manner similar to recapture under the tax laws. There are procedures to protect the right of recapture without resorting to across-the-board abolition of accelerated depreciation. One such alternative is a regulation requiring the seller and purchaser of any health facility participating in the medicare program to give not less than 30 days' notice to the Social Security Administration prior to the sale of assets. This procedure would provide the Federal Government with an opportunity to intervene in order to protect its interest. This could

be accomplished by an attachment of assets, if necessary, or reaching an agreement on suitable arrangements. If the parties to the sale or transfer of assets failed to give proper notice to Social Security Administration, the buyer would not be certified to participate in the medicare program.

This procedure is being used in California under the State medicaid program at this time.

We also believe that the new purchaser of a health care facility should be allowed to depreciate property purchased in an arm's length transaction at the then existing market value as determined by independent appraisals.

INTERMEDIARIES

We do not agree with the committee staff recommendation—p. 114—that the right of providers to select intermediaries should be terminated and the selection left to the Secretary of HEW. While we certainly agree that the Government should have some control over the final approval of a designated intermediary, complete control would simply result in increased problems in the attempt to develop working relationships between providers and intermediaries. On the other hand we understand the Committee staff's concern that the right to select intermediaries not be abused or used as a club.

We therefore recommend that providers continue to select intermediaries subject to the approval of the Department of HEW and that changes in intermediaries be limited to situations where the Secretary of HEW finds reasonable cause for the change and that such change will be in the best interests of the program.

By that we mean that the Secretary should also have the right to request change as well as the intermediary.

In addition providers should be required to change intermediaries where the Secretary determine that the intermediary is not doing an effective job. We believe that proposal would be facilitated by allowing the Secretary to deal directly with their intermediaries rather than having to go through the intermediary's national organizations, and we believe the House committee staff has so provided in its report.

In regard to the appeal mechanism, the Federation of American Hospitals recommends the adoption of an appeals mechanism for providers. The present Social Security Act contains no provisions for administrative recourse by providers from the decisions of intermediaries. The only procedures for administrative or judicial review pertain to the initial determination of eligibility to participate in the medicare program and to any subsequent decision terminating participation.

We believe this is one of those rare instances in our Anglo-Saxon tradition where a party with a grievance has no recourse from a decision of the interested party on the other side of the controversy. Those intermediary hearing procedures which exist are by their very nature partial and limited. Conflicting interpretations by different intermediaries remain unresolved. The "extremely wide variation in the levels of performance of the intermediaries"—staff report, p. 116—would be narrowed by a national appeals mechanism.

PLANNING

We have already outlined the commitment of investor-owned institutions to work within a system which is coordinated and ordered by the planning process. Federation of American Hospitals supports an amendment to the medicare program under which reimbursement for depreciation or return on equity capital with respect to any future capital expenditure made by a provider against the recommendation of the "appropriate and technically qualified" State or local planning agency would be disallowed—(staff report, p. 6). The quotation is from page 6 of the staff report, and I think it is particularly pertinent because, for the first time in any document that I have seen, reference is made to a technically qualified as well as to an appropriate agency. I have had the personal experience of living since 1969 with health planning in the State of California, have spent literally thousands of hours at meetings of various health planning organizations and agencies, have served as cocounsel of our local agencies through our local planning agencies, and have assisted in the drafting of the regulations which we have in California. In order for an institution to subject itself to the benefits which can be derived from orderly planning, it should have the assurance that the people who are doing the planning are competent to do so.

With that qualification, we support completely the position you have stated.

On audit costs, the staff report quite correctly concludes that cost finding and auditing have proved "highly expensive undertakings" and "a source of much friction." (Staff report, p. 47.) We share the staff's recomendation that cost-findings procedures be revised and simplified to reduce duplication and that simpler cost data be required for smaller facilities.

We believe, for example, that the statement of a certified public accountant presenting uniform data with respect to all of the programs in existence in the hospital, such as Blue Cross, medicare, and medicaid, would be the appropriate starting place, wtih spot audits following from there.

On page 15, the staff has also recommended payment of interest by the Government on amounts due to facilities which remain unpaid more than 60 or 90 days after adequate data has been submitted and a similar requirement that institutions pay interest to the medicare program where unusual delay in settlement is caused by the facility. This proposal has merit, particularly for most of our providers who have waited for years for completion of their audits, for interpretations of regulations, and for decisions to be made. However, we would be wary of any such provision enacted without the opportunity for administrative and judicial review. Unless an appeals procedure were adopted, such a penalty would not likely be self-imposed by Government very frequently and providers would have no recourse from determinations of the causes of delay in reaching final settlements.

UTILIZATION REVIEW

We favor steps to strengthen the utilization review procedures but caution against arbitrary application of standards by those not involved with the daily procedures of the facility.

The Federation of American Hospitals supports experimentation with exchanging physicians among hospitals—perhaps on a rotating basis—to serve on utilization review committees (as recommended by the committee staff, p. 109), however, we believe that it would be wise to retain at least one member of the committee who is affiliated with a hospital and familiar with its internal procedures.

We mention in a summary fashion some of the problems we foresee in this type of rotating utilization review, and they are not to be minimized.

Where there are physicians who own a financial interest in the facility, we would argue that at least one should be allowed to serve on the utilization review committee, leaving a majority free of even the remotest appearance of a conflict of interest. Waivers to such a regulation should be obtainable in special circumstances such as rural areas where other physicians are not readily available.

We support the committee staff's recommendation that data on average lengths of stay and service requirements in a locality be made available to review committee members in each institution. We would also welcome experimentation with computers to determine communitywide guidelines for lengths of stay and services with the admonition against overreliance on these purely statistical devices. We do support, of course, the proposal exempting physicians from liability for service from these committees. I am quite certain there are already several cases in the courts on this. I believe there is one in California.

On the subject of public companies, the recent growth of multifacility corporations or "chains" as they are commonly called has produced a good deal of discussion among those actively involved in the health field. It has also been a fertile subject for magazine writers in all the health publications. This in itself is a healthy sign because the more alternatives and resources which can be developed to meet the demand for quality care, the more efficient and economical the system will become. This, of course, assumes that the public companies comply with the same standards and operate within the same framework as other institutions in the health field.

Many of the concerns voiced about the chains, including those which appear in the staff report (pp. 135–143) we believe, can be relieved by strengthening existing controls and applying them equally to all facilities. These include State planning bodies; tying reimbursement for capital expenditures to planning approval; utilization review; being strengthened and existing regulations governing compensation, dealings between related organizations, and the determination of cost bases where assets are transferred.

However, we believe in dealing with these subjects that consultations should take place with those most intimately involved who can make recommendations, where we believe that the program would be served and yet conflict could be avoided in unnecessary ways.

We believe it is important to place these concerns in proper perspective—to understand that the vast majority of these new companies operate without abusing the medicare-medicaid programs but rather present a real opportunity for achieving meaningful cost controls and increased efficiencies without sacrificing quality care. This point is recognized by the committee staff but tends to be lost whenever the rare but memorable exception is exposed.

We believe that the voluntary nonprofit sector of the health field has also recognized the benefits of this type of operation, and we noticed with great interest the number of such organizations emerging in the voluntary nonprofit portion of the field, particularly one in Senator Fannin's State which is quite well along in development, the Good Samaritan Health Services Center.

The investor-owned hospitals of America, as an integral part of the Nation's health industry, are ready to cooperate with Government and others to meet the challenges of the future.

We believe that private initiative is the most effective instrument we have to achieve our common goal of high quality health care for all at a reasonable cost. The reduction of health care costs is a meritorious goal but achieving it without adversely affecting the quality of care is difficult. Responsible authorities in the health field concur that hospitals have grown up. We are now major and complex social institutions. The potential of the profit incentive should be explored as a means of achieving that delicate balance between quality care and reasonable costs.

We are pleased to have had the opportunity to appear before you, Mr. Chairman, and members of the Committee, and we are ready to answer any questions.

(The complete statement of Mr. Memel follows:)

STATEMENT OF SHERWIN L. MEMEL AND SAM A. WEEMS

Mr. Chairman and Members of the Subcommittee, I am Sherwin L. Memel, a Vice-President of the Federation of American Hospitals and Chairman of its Bureau of Health Insurance Liaison Committee. I am also a recent appointee to the Health Insurance Benefits Advisory Council (HIBAC), the statutory advisory committee for the Medicare program. With me is Mr. Sam A. Weems, Director of the Federation's Legislative Bureau.

The Federation of American Hospitals is the national association of investor-owned (proprietary) hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations. Our member institutions range from small rural facilities to the largest investor-owned comprehensive medical care complex in the Nation.

The Senate Finance Committee staff in its report has focused on a number of problem areas in the Medicare and Medicaid programs and we concur with many of the findings set forth in the Committee staff report, "Medicare and Medicaid-Problems, Issues and Alternatives". Specifically, the Federation of American Hospitals agrees with the Committee staff that utilization review has "generally speaking" been "ineffective as a curb to unnecessary use of institutional care and services", and we see a real need for meaningful and effective utilization review procedures for all levels of institutional care. Federation agrees with the Committee staff that there have been "inordinate and protracted delays in final settlement of accounts" and we share their concern about high administrative costs and audit "overkill". We concur that intermediary performance "varies widely" and we urge action to correct the lack of uniformity and timeliness in interpretations of the program regulations. We agree that more effective Internal Revenue Service reporting requirements covering payments under the programs are needed and we communicated our support for such reporting requirements to the Chairman of the Senate Finance Committee in July of 1969.

The investor-owned hospitals of America are committed to providing quality health care at reasonable cost and we believe that the free-enterprise sector of the hospital field can make a significant contribution to the department of a more efficient and more effective delivery system. This can be done by stimulating competition and providing alternatives to the consumers of health care—all within the framework of a single system.

The following recommendations are made by the Federation of American Hospitals with a view toward short-range improvements in the Medicare-Medicaid programs and also as basic ingredients in the development of a new health care delivery system which can in time meet the needs of all Americans.

PROSPECTIVE INCENTIVE REIMBURSEMENT

The Federation of American Hospitals supports a broad program of experimentation on a voluntary basis with a number of prospective rate formulas in order to determine which method would be most equitable to the providers and purchasers of hospital care. We note in chapter eight of the Committee staff report that an incentive reimbursement proposal is being drafted by the staff. We would welcome the opportunity to cooperate in the formulation of such a proposal.

Investor-owned hospitals have never been pleased with the mechanics of a retroactive cost reimbursement under Medicare. The lack of predictability, time and expense of multiple audits and lack of incentives for developing new efficiencies are just some of the weaknesses inherent in any formula which simply pays for cost.

On the other hand, we would caution that the concept of prospective reimbursement or the use of a so-called negotiated rate is subject to literally hundreds of interpretations and variations, depending on what components are used to arrive at the prospective rate. Another problem in pinning down the details of a prospective rate formula with which we are struggling, has been the question of the starting point or base from which the rate is to be derived.

A Committee of Federation of American Hospitals, the Bureau of Health Insurance Liaison Committee, which I chair, has been meeting with the Social Security Administration during the past few months in an effort to develop a pilot program under the Incentive Reimbursement authority of Title XVIII. The basic features of our proposal include a rate based on the average costs of all hospitals in a locality, grouped under a classification system based on size and scope of services. A reasonable profit—either a fixed percentage or the difference between average charges and average costs in the locality would be added to the base rate. Additionally, the rate would be tied to agreed upon indices to reflect average cost increases. However, this total rate would be fixed and the provider would be required to absorb all costs in excess of that rate.

This type of prospective rate would provide the economic incentives to which the Committee staff has referred. It would match hospitals of similar size and scope of services against a standard, encouraging competition with a goal of stabilizing hospital costs through a system of rewarding those institutions which provide quality care while operating below community-wide levels, thereby bringing down or at least containing costs in the locality.

The difficulties encountered by providers as well as those responsible for administering the Medicare-Medicaid programs are most troublesome in the area of determining reasonable costs. While a growing number of health officials now favor some form of prospective reimbursement as the ultimate solution to this problem, there remains a need under present reimbursement regulations to make the determination of reasonable cost more equitable. This problem must be resolved swiftly and accounts finalized without further delay.

We support the proposed reimbursement for additional nursing costs for Medicare patients. Studies have demonstrated the existence of these costs and we hope the promised adjustment will be implemented retroactive to July 1, 1969.

While we understand the mounting pressure for cost controls under Medicare and Medicaid, we cannot concur with arbitrary controls drafted with little concern for the economic plight of institutional providers, whose costs have soared largely as a result of increased labor costs, new equipment requirements and obsolescence.

In this regard, we do not support the Committee Staff recommendation (Staff Report, p. 53) that accelerated depreciation be eliminated under Medicare. The original purpose of these Medicare regulations—to assist providers maintain sufficient cash flow to service their debts on assets, is more relevant today than it was in 1965. Some modifications may be needed to protect the program against overpayment in situations where assets are transferred without recovery by the government of the excess of accelerated over straight-line depreciation.

In that event we believe the government should be able to recapture the excess in a manner similar to recapture under the tax laws. There are procedures to protect the right of recapture without resorting to across the board abolition of accelerated depreciation. One such alternative is a regulation requiring the seller and purchaser of any health facility participating in the Medicare program to give not less than 30 days notice to the Social Security Administration prior to the sale of assets. This procedure would provide the Federal Government with

an opportunity to intervene in order to protect its interest. This could be accomplished by an attachment of assets, if necessary, or reaching an agreement on suitable arrangements. If the parties to the sale or transfer of assets failed to give proper notice to S.S.A., the buyer would not be certified to participate in the Medicare program.

We also believe that the new purchaser of a health care facility should be allowed to depreciate property purchased in an arms length transaction at the then existing market value as determined by independent appraisals.

INTERMEDIARIES

We do not agree with the Committee Staff recommendation (p. 114) that the right of providers to select intermediaries should be terminated and the selection left to the Secretary of HEW. While we certainly agree that the government should have some control over the final approval of a designated intermediary, complete control would simply result in increased problems in the attempt to develop working relationships between providers and intermediaries. On the other hand we understand the Committee staff's concern that the right to select intermediaries not be abused or used as a club.

We therefore recommend that providers continue to select intermediaries subject to the approval of the Department of HEW and that changes in intermediaries be limited to situations where the Secretary of HEW finds reasonable cause for the change and that such change will be in the best interests of the program. In addition providers should be required to change intermediaries where the Secretary determines that the intermediary is not doing an effective job.

APPEALS PROCEDURE

The Federation of American Hospitals recommends the adoption of an appeals mechanism for providers. The present Social Security Act contains no provisions for administrative recourse by providers from the decisions of intermediaries. The only procedures for administrative or judicial review pertain to the initial determination of eligibility to participate in the Medicare program and to the subsequent decision terminating participation.

We believe this is one of those rare instances in our Anglo-Saxon tradition where a party with a grievance has no recourse from a decision of the interested party on the other side of the controversy. Those intermediary hearing procedures which exist are by their very nature partial and limited. Conflicting interpretations by different intermediaries remain unresolved. The "extremely wide variation in the levels of performance of the intermediaries (Staff Report, p. 116) would be narrowed by a national appeals mechanism.

PLANNING

We have already outlined the commitment of investor-owned institutions to work within a system which is coordinated and ordered by the planning process. Federation of American Hospitals supports an amendment to the Medicare program under which reimbursement for depreciation or return on equity capital with respect to any future capital expenditure made by a provider against the recommendation of the "appropriate and technically qualified" State or local planning agency would be disallowed (Staff Report, p. 6).

AUDIT COSTS

The Staff report quite correctly concludes that cost-finding and auditing have proved "highly expensive undertakings" and "a source of much friction." (Staff Report, p. 47). We share the staff's recommendation that cost-findings procedures be revised and simplified to reduce duplication and that simpler cost data be required for smaller facilities.

The staff has also recommended payment of interest by the government on amounts due to facilities which remain unpaid more than 60 or 90 days after adequate data has been submitted and a similar requirement that institutions pay interest to the Medicare program where unusual delay in settlement is caused by the facility. This proposal has merit. However, we would be wary of any such provision enacted without the opportunity for administrative and judicial review. Unless an appeals procedure were adopted, such an interest

penalty would not likely be self-imposed by government very frequently and providers would have no recourse from determinations of the causes of delay in reaching final settlements.

UTILIZATION REVIEW

We favor steps to strengthen the utilization review procedures but caution against arbitrary application of standards by those not involved with the daily procedures of the facility.

The Federation of American Hospitals supports experimentation with exchanging physicians among hospitals—perhaps on a rotating basis—to serve on utilization review committees (as recommended by the Committee staff, p. 109), however, we believe that it would be wise to retain at least one member of the committee who is affiliated with a hospital and familiar with its internal procedures.

Where there are physicians who own a financial interest in the facility, we would argue that at least one should be allowed to serve on the utilization review committee, leaving a majority free of even the remotest appearance of a conflict of interest. Waivers to such a regulation should be obtained in special circumstances such as rural areas where other physicians are not readily available.

We support the Committee staff's recommendation that data on average lengths of stay and service requirements in a locality be made available to review committee members in each institution. We would also welcome experimentation with computers to determine community-wide guidelines for lengths of stay and services with the admonition against over-reliance on these.

PUBLIC COMPANIES

The recent growth of multi-facility corporations or "chains" as they are commonly called has produced a good deal of discussion among those actively involved in the health field. This in itself is a healthy sign because the more alternatives and resources which can be developed to meet the demand for quality care, the more efficient and economical the system will become. This, of course, assumes that the public companies comply with the same standards and operate within the same framework as other institutions in the health field.

Many of the concerns voiced about the chains, including those which appear in the Staff Report (pp. 135–143) we believe, can be relieved by strengthening existing controls and applying them equally to all facilities. These include state planning bodies; tying reimbursement for capital expenditures to planning approval; utilization review being strengthened; and existing regulations governing compensation, dealings between related organizations, and the determination of cost bases where assets are transferred.

It is important to place these concerns in proper perspective—to understand that the vast majority of these new companies operate without abusing the Medicare-Medicaid programs but rather present a real opportunity for achieving meaningful cost controls and increased efficiencies without sacrificing quality care. This point is recognized by the Committee staff but tends to be lost whenever the rare but memorable exception is exposed.

If we can agree that a pluralistic system of health care is in the best interest of the public, then we believe such a system will welcome the contribution which the multi-facility corporation can make as part of the investor-owned sector of the voluntary hospital field.

THE FUTURE

The investor-owned hospitals of America, as an integral part of the Nation's health industry, are ready to cooperate with government and others to meet the challenges of the future.

We believe that private initiative is the most effective instrument we have to achieve our common goal of high quality health care for all at a reasonable cost. The reduction of health care costs is a meritorious goal but achieving it without adversely affecting the quality of care is difficult. Responsible authorities in the health field concur that hospitals have grown up. We are now major and complex social institutions. The potential of the profit incentive should be explored as a means of achieving that delicate balance between quality care and reasonable costs.

Senator ANDERSON. We have a time problem because of a pending vote in the Senate.

Senator Ribicoff?

Senator RIBICOFF. I have just two questions.

In comparison with proprietary hospitals, would you say the community nonprofit hospitals develop the same kind of efficiency in the use of personnel?

Mr. MEMEL. If you are asking me to comment on a nationwide basis, I think in all honesty, my answer would have to be no. If you are asking me to comment on an individual hospital-by-hospital basis, I think strong cases can be made for better efficiency in an individual community situation for other type ownership.

Senator RIBICOFF. Where does the initiative have to come on this?

Mr. MEMEL. The initiative for better productivity? Is that your question?

Senator RIBICOFF. Yes.

Mr. MEMEL. We believe that the problem begins at a very fundamental level, one that we believe is recognized by the trustees of most of America's voluntary nonprofit hospitals today. That is that there has to be a commitment by the board to their institution. There has to be a full-time management, and we believe in those voluntary nonprofit hospitals where the boards of trustees have such commitments, you do find first-rate management.

In those institutions where it is honorary service, part-time commitment, perpetuation in office, we believe the weakness begins there.

We believe further that the schools of hospital administration have not concentrated in any way sufficiently on the business aspects of running these very major, complex, as well as social institutions that hospitals have become.

So we believe that qualified business people are required at the highest management levels of these hospitals. We do not believe they have been there up until now. We believe these are the beginning places.

Senator RIBICOFF. Thank you, Mr. Chairman.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. Why do people stay in the hospital too long?

Mr. MEMEL. Not all people do stay in the hospital too long.

Senator CURTIS. Those that do stay too long, why is it?

Mr. MEMEL. I think a variety of reasons, primarily the one that was emphasized in the testimony earlier this morning. That is that our entire system for the payment of health care has emphasized payment only so long as you are hospitalized. So the pressures put on the physician by the patient and his family are so immense that they are involved and put in the hospital.

I have talked to physicians who have been presidents of State medical societies who have condemned in quite outspoken terms physicians for succumbing to these pressures and allowing their patients to convince them to either hospitalize them initially when they are not required to be hospitalized, for the purpose of getting away from the small deductible or keeping them too long. The fact of the matter is that this occurs. I think a change must occur, and I think the health insurance industry now recognizes that such changes must occur. I believe they have a policy statement dated October 28, 1969, from the board of directors, which recognizes that this is in error.

Senator CURTIS. Does anybody have any economic incentive to prevent this from happening? Is there anybody who receives a gain when a case is efficiently handled?

Mr. MEMEL. I believe that the only system which has been suggested to benefit somebody when the case has been most efficiently handled has been the Kaiser system. There, of course, you have the situation where the physicians benefit from lowering utilization as opposed to higher utilization of the hospital system.

Senator CURTIS. Of course, that is quite a different method of practice, too, is it not?

Mr. MEMEL. It is a totally different method of practice, and Dr. Sidney Garfield, in last month's issue of Scientific American—he is, of course, the father of the Kaiser system—has written an extraordinarily interesting article which I would commend to the staff if they have not already seen it about the Kaiser system. He states that he does not even now believe that the Kaiser system has gone as far as it can, because by eliminating the fee for service system—they realize they have taken out of the system the one deterrent to excessive utilization. He is now suggesting a new model to be utilized by the Kaiser system and other systems that will follow to substitute for this deterrent factor.

I think the committees that are now studying this subject are coming to the conclusion—I know I personally am—that what is needed is a system of health delivery organizations around the United States both prepayment and on a quasi prepayment basis, where there will be some form of capitation to the health-delivery organizations, leaving within the organizational structure itself a variety of payment mechanisms to hospitals, to other institutional providers, and to the physicians, so it can be either fee for services or salaries.

This type of thing ultimately has to be the solution for presenting alternatives to proper health care and proper utilization. But it can only succeed if the Federal Government sets out uniform standards to be applied around the United States.

I also feel that enough attention has not been paid to the role of environmental health care, and if we look at the picture down the road, I do not think it is realistic to expect that per diem health costs in hospitals will go down as long as we try to restrict them more and more to acutely ill patients. Per diem costs, if we are successful in reorganizing our system, should go up. It is the total cost of the whole program which we feel should go down or be contained.

Senator CURTIS. Just applying my question to the existing programs of medicare and medicaid, is the patient or the hospital or the intermediary or the provider or the extended care home, or is there anyone, including the patients themselves, who has any economic incentive for minimizing the utilization?

Mr. MEMEL. Well, your question is broad and I assume you do not mean the paying agency. Of course, they have an incentive for minimizing utilization.

Senator CURTIS. The paying agency?

Mr. MEMEL. The paying agency, of course, does have an incentive to minimize utilization, such as the medicaid program, or medicare, or the insurance company. But in terms of the provider, there is not, except in a very few experimental programs of this type, if I understand your question correctly, any economic incentive to move the patient through the system faster.

Senator CURTIS. And the coinsurance, which was intended as a sort of incentive for the patient, is a fixed dollar amount rather than a percentage of the bill; is that not right?

Mr. MEMEL. That is correct. This is on the part A program.

Senator CURTIS. Would not the percentage be better?

Mr. MEMEL. Are you talking about a deductible or coinsurance? I believe in coinsurance, percentage might possibly be more effective.

Senator CURTIS. Yes; if a certain type of care is extended for $50 a day and the patient pays $6.50, this is an extended care facility, the Government pays $43.50. But if that patient is moved to another room where the cost is $80 a day, the patient still pays $6.50, but the Government pays $73.50 instead of $43.50. Is that not right?

Mr. MEMEL. I am sorry, I did not follow your mathematics, Senator. I would have to go through them again.

Senator CURTIS. Well, the time is short, but I think that is true. I think what we have here in this big Government program is that there are not enough incentives along the way where it is to somebody's advantage to do a good job.

Mr. MEMEL. I believe, if I may, Senator Curtis, that while this area of patient incentive is an important one, the real incentive will be in going toward a prospective reimbursement program in providing economic incentive to the providers and putting them on their mettle, testing them against their peers, with proper quality controls.

I believe also that combining part A and part B has definite merit to recommend it. I believe consideration must be given to the fact that it is the physician, in the final analysis, who controls utilization.

When you talk about unnecessary admission or unnecessarily protracted length of stay, it is the rare situation where the hospital as an entity has any control. It is the physician within an institution.

Senator CURTIS. You think it is more the physician than the patient?

Mr. MEMEL. Yes.

Senator CURTIS. If there is overutilization, your answer is that the physicians are primarily responsible?

Mr. MEMEL. Well, the physician succumbs to human emotion and to the economic plight of the patient. I believe that these pressures on the physicians are very understandable and that if the system is changed so that these pressures are not on him, we will see a drastic change in utilization.

Senator ANDERSON. Senator Fannin?

Senator FANNIN. Yes, Mr. Chairman.

Mr. Memel, I was very impressed with your presentation, and especially interested in your remarks about the business acumen so essential to a proper program and to the goals we are all seeking. I am wondering if you are familiar with the bill that I introduced, S. 2705, to provide for medical and hospital care through a system of voluntary health insurance?

Mr. MEMEL. That is the bill which is called Medi-Credit for short?

Senator FANNIN. Yes, you would get credit on your income tax return.

Mr. MEMEL. I have had the opportunity to read the bill and the explanatory material in the past.

Senator FANNIN. Would you be willing to send your comments to the committee on this bill?

Mr. MEMEL. I certainly will, sir.*

Senator ANDERSON. Mr. Memel, could you return at 2:30?

Mr. MEMEL. Yes, sir.

Senator ANDERSON. You may have only staff questioning, because Senators may be over on the floor of the Senate. If you could return at 2:30, we will appreciate it very much.

Mr. MEMEL. Yes, sir, we will, thank you, sir.

Senator ANDERSON. Mr. Hutchison, will you come forward, please?

Senator WILLIAMS. Mr. Chairman, it is obvious we are not going to be able to get through all the witnesses here this morning. I wonder if we could not discuss now when they will be able to get back. I think the suggestion has been made that if it is convenient with the other witnesses, we hear them next Tuesday. That means those who will be scheduled next Tuesday will be Mr. Keith Hutson, president of the National Council of Health Care Facilities; Dr. Lowell E. Bellin, of the New York City Department of Health, and Mr. John A. DeCell, president of Medicenters of America, Inc.

Could they arrange with the staff of the committee to return next Tuesday?

Arrangements are also being made to change the witnesses from tomorrow, I understand, as follows:

The American Nursing Home Association and the American Association of Homes for the Aged, and the Council of Teaching Hospitals of the American Association of Medical Colleges, are going to be moved over to June 3.

Those of you here today, we would like to move you over to 10 o'clock on June 2.

Senator ANDERSON. We shall proceed to hear from Mr. Hutchison now.

STATEMENT OF JOHN D. HUTCHISON, EXECUTIVE DIRECTOR, IDAHO HOSPITAL ASSOCIATION; ACCOMPANIED BY SISTER M. DIANE MOELLER, ADMINISTRATOR, SACRED HEART HOSPITAL, IDAHO FALLS; AND CHRIS ANTON, CONTROLLER, ST. ALPHONSUS HOSPITAL, BOISE

Mr. HUTCHISON. Mr. Chairman, I am John Hutchison, the executive director of the Idaho Hospital Association. I am here today on behalf of that association.

I am accompanied by Sister M. Diane Moeller, administrator, Sacred Heart Hospital, Idaho Falls; and Chris Anton, controller, St. Alphonsus Hopsital, Boise.

The Idaho Hospital Association is an association of small hospitals in a sparsely populated State (approximately 720,000) covering a geographic area of 83,577 square miles. We have 46 general acute hospitals, the majority of which are under 50 beds and none with over 200 beds. These hospitals are performing a vital role in meeting the health needs of the community they serve.

*At presstime, August 10, 1970, the comments referred to had not been received by the committee.

Inasmuch as we are from a rural State with few hospitals, we have been able to watch closely and observe the medicare program, which has served a definite need. However, like most programs, there need to be changes in the program to meet intent of Congress when the bill was passed and signed into law.

President Johnson, in signing the legislation into law in 1965, was aware of inherent flaws and made reference to the possible need of legislative amendments. After 5 years, our hospitals are continuing to work under, in our opinion, unnecessary burdens and problems as pertains to this program.

Our hospitals are charged with the responsibility of delivering health services to Idaho citizens in as efficient a manner as possible and still provide the necessary and needed care—to all patients, not just one segment. This includes the medicare patients. Our hospitals do not classify patients, they provide service for those in need. This is our role and our function and to do otherwise would be morally and ethically wrong. To fulfill this role we must be ever alert and aware of ways to improve. We feel we are improving patient care through our management engineering program (see exhibit A), consolidation of services, sharing of personnel, group insurance programs, and others. Hopefully, very shortly our association will announce a group purchasing program to further save the patient. The engineering program, shared services, et cetera, are examples of voluntary programs undertaken by hospitals to improve care and reduce costs.

We are pleased to have been asked to appear before you today to inform you of the problems which we face in attempting to work with Government to provide a service to a large segment of our population. There are many problems which we feel can be solved to make the program more workable. We will present to you the ones which in our opinion are the most pressing and in need of immediate attention by this committee and the Social Security Administration.

Rural America is not industrialized; therefore, fewer of its citizens are afforded the opportunity of purchasing group health insurance. Therefore, the bad debts of rural hospitals are generally much higher than in urban areas, and with our hospitals having to discount medicare, this simply increases our writeoffs which adds an increased burden to those paying billed charges. What is the reasoning behind SSA not participating in bad debts other than for medicare patients? If this reason applied to all third-party payers and patients who pay cash—then whose responsibility is it to pick up bad debts? Should taxpayers pay school taxes if they have no children in school? If this attitude prevailed in all tax programs, we can see endless problems. Thus, why is this concept forced on our Nation's hospitals?

Medicare does not make any provision for debt retirement, except through the payment of interest and depreciation. Since generally debt is amortized over a shorter period of time than an asset is depreciated, the amount of funds needed to amortize the debt must be paid by nonmedicare patients. Is this proper? If a hospital's patient load was all medicare patients, under the above cited provisions, then a hospital building is no longer usable, the hospital will be out of business. Hospitals, like other businesses, must save for the future or "dry up and wither on the vine."

We are aware that Congress is concerned with the cost of health care and primarily the cost of medicare. We share your concern. However, we do not believe it was your intent to pay for less than cost when you passed the medicare law.

Our recommendation for a solution to this issue is to permit payment on a prospective basis rather than retrospective and adhere to the American Hospital Association's "Statement on the Financial Requirements of Health Care Institutions and Services." However, we urge extreme caution and deliberation prior to changing to the prospective basis inasmuch as there are disadvantages to such a manner of payment.

If the existing regulations continue as related to payment, the nonprofit hospitals will be "squeezed out" or they will of necessity have to eliminate their medicare contracts because it is unfair for the hospital to continue to receive less than cost which forces the administration to raise the charges to the non-medicare patient.

We also recommend that the patient be required to pay a percentage of his total bill. This could bring about a dramatic impact on utilization, the periodic arbitrary regulatory adjustments would be obviated except for possible adjustments in percentage figures if needed, and tremendous administrative costs could be eliminated. This would eliminate the injustice to our other patients.

The part A and B division should be changed. One suggested solution is to place all hospital related institutional-type care under part A and all nonhospital and institutional professional care under part B. If this were changed, we feel some of the problems would disappear.

The provision relating to the spell of illness is not only troublesome for the hospitals and fiscal intermediary but confusing to the patient. If the above suggested changes were made—having the patient pay a percentage of the bill—then the spell of illness feature could be eliminated and undoubtedly this change would eliminate many problems for the hospitals and much heartache for the patient.

We suggest a change in the printed materials which are being circulated by SSA to the public. Much of the information states that the patient is entitled to certain coverage, when in fact the patient is entitled to coverage only if he or she meets certain requirements.

One of the most dramatic problems is in the area of utilization review. How can there be effective utilization review in a community hospital with one, two or three physicians practicing in the community?

We have many situations where one, two, or three physicians are practicing. We believe that utilization review is controlled by the community itself. We suggest utilization review be eliminated when there are so few physicians.

We feel that the fiscal intermediary could spot check hospitals and if the length of stay is excessive, then officials of the intermediary, hospitals and physicians could informally discuss the problem.

Some of our hospitals are experiencing problems where medicare disallows a claim or disallows it after a certain period of time. This is unrealistic and unfair to the hospital and patient. The hospital does not admit or discharge a patient, it provides a service upon the orders of a physician. However, on a number of occasions, hospital bills in Idaho have been disallowed because on someone's or some committee's

advice after reviewing the case on paper hundreds of miles from the hospital, the service is deemed unnecessary.

Is it right that a hospital be denied payment in these cases? Why should the hospital be penalized?

One of the most costly items concerned with medicare is the paper work and the duplication of audits. It has been reported that the Federal Government paid, in 1968, approximately $80 million to independent auditing firms to audit the hospitals by staff of SSA and GAO (Government Accounting Office) to determine if the independent auditor has done his job in addition to the audit or accounting check performed by the fiscal intermediary. What is the real cost of the medicare audit?

In addition to the audits mentioned above, the hospital has an audit performed by an independent auditing firm and in many cases the firm which does the medicare audit does the independent audit for the hospitals. The duplication is a gross waste of taxpayer's and patient dollars. Our solution is that SSA accept the audit by the hospital's independent audit with modifications, if deemed necessary, to meet specific medicare requirements.

The present cost reporting requirements impost an unnecessary administrative burden on small providers in rural areas. This burden is expressed in both staff time and direct expense, such as increased fees resulting from consultation and preparation of reports by outside auditors. One administrator from a 30-bed hospital in Idaho reported that the charge made by an outside auditor to prepare the required medicare report was in excess of $6,000. The cost report as required by regulations generally cannot be developed in the small hospital by existing staff. The business office staffs do not generally have the capabilities; therefore, must rely on expensive professionals from auditing firms. I was told recently that hospitals shouldn't concern themselves with this cost because it was a reimbursable expense under medicare. This is gross misrepresentation. For example, in the hospital cited, if a third of the patients were medicare, then the medicare program would reimburse only $2,000, not the full $6,000. The remaining $4,000 would be paid by the nonmedicare patient. The complicated cost report does nothing for the nonmedicare patient. If the medicare philosophy is to pay for only services used by medicare patients, then why doesn't the program pay all costs which are inflated due to unreasonable requirements that serve no useful purpose to nonmedicare patients?

Under medicare, small providers should be allowed to recover program costs on the basis of an average cost per diem. If SSA would accept average per diem, then reporting on the basis of costfinding would not serve any meaningful purpose in determining overall reimbursement.

Other forms of paperwork such as the medicare log and admitting and billing forms are costly and serve no major purpose. One hospital in Idaho has employed a full-time clerk to maintain the medicare log; however, this is not totally reimbursable under medicare.

Mr. Chairman and members of the committee, these are the forms required under the medicaid program in admitting one patient. These are the forms required.

We suggest a simplication such as those by Blue Cross or commercial insurance companies, or possibly a simple credit card approach. The billing forms required for inpatient and physician should be combined.

SSA has a committee of hospital consultants to advise on forms and procedures. This committee should be expanded to have representation of hospital personnel from hospitals of under 100 beds. Many of the recommendations of this committee have not been acted upon, however, those which have been accepted have resulted in reduced administrative time, improved cash flow which keeps charges down. The value of this committee should be recognized and its recommendations acted upon where possible.

The rules and regulations as affects certification of providers should be relaxed. A requirement that a registered professional nurse be on duty in the hospital 24 hours a day seems to us a bit unrealistic. If this requirement were carried to its fullest degree, a 600-bed hospital with one RN would meet the requirement but a 30-bed hospital not having a RN on one shift in a given week, but a nurse on call, would not be in compliance with the regulations. Granted, this is an extreme example and no hospital by choice does not cover all shifts with an experienced RN. However, at times the small hospital cannot get a qualified RN. Should that hospital be closed under that situation when the closest available hospital is 50 or 100 miles away, and in many cases over mountain roads, and during the winter these roads are icy or snowpacked? The point we are attempting to make is that factors and situations are different from area to area and rural versus urban. Shouldn't these factors be considered when regulations are established? Must a rural hospital in a farming community of Idaho adhere to the same regulations as a large hospital in New York City—is this realistic? Is the quality of care judged by adherence to unrealistic regulations or is it judged by the type of care given?

During the last fiscal year, a 150-bed hospital in Idaho had contractual adjustments for medicare of $119,787. The total patient-days at the hospital during the same period was 48,429 of which 16,374 were medicare. The cost of the medicare writeoffs equaled approximately $4 per patient-day for the nonmedicare patient. In other words, the nonmedicare patient had to pay on top of an already high hospital bill $4 per day to cover the medicare loss. If the public were fully aware of this inflated hospital bill, I wonder what would happen?

Our hospitals and physicians resent the negative philosophy regarding certification and recertification of the medicare patient. In basic terms, this philosophy states hospitals and physicians are going to "cheat" the program; therefore, we must put a "watchdog" out in the form of the certification and recertification requirements. In most cases, this requirement is costly and unnecessary. There are standards which have been developed on average stays. Why can't the fiscal intermediary watch length of stays and should a provider abuse it, appropriate action be taken? Why penalize all providers for the acts of a few?

In summary, we would like to reemphasize to you that the medicare law has been a benefit to many, that we are as concerned as you with the cost of health care and that we in the health care industry are attempting to control costs in many areas. We feel there are many ways in which HEW can reduce costs in the medicare program, a few of

which have been raised in this testimony: duplicate audits, paperwork, certification requirements, et cetera, and some not elaborated on such as tremendous staffs in the central office of SSA and regional offices which are required to enforce regulations, act as consultants, et cetera.

The providers accepted medicare in the beginning in good faith and have gone beyond the call of duty to make it work. These same providers are, after 5 years, eager to continue their efforts to help make the system work. We trust that you will work with us so that our system can continue to function.

And, Mr. Chairman, one last comment. We believe in experimental programs, as we heard the Senator from Connecticut mention a few moments ago. Would it be possible for the Social Security Administration and Government to attempt an experimental program by contracting for the medicare and medicaid program through existing media such as the commercial insurance companies or Blue Cross? Why cannot this be done on an experimental basis? The mechanism is set up. Would we not eliminate high administrative costs?

Would it work? We do not know. But we would suggest that it might have some merits.

Thank you, Mr. Chairman.

(The prepared statement of Mr. Hutchison and an additional statement submitted by the association follows:)

PREPARED STATEMENT OF THE IDAHO HOSPITAL ASSOCIATION ON PROBLEMS RURAL HOSPITALS ARE HAVING WITH THE MEDICARE PROGRAM

Mr. Chairman, I am John D. Hutchison, Executive Director of the Idaho Hospital Association and I appear here today on behalf of the Association. I am accompanied by Sister M. Diane Moeller, Administrator, Sacred Heart Hospital, Idaho Falls; and Chris Anton, Controller, St. Alphonsus Hospital, Boise.

The Idaho Hospital Association is an association of small hospitals in a sparsely populated state (approximately 720,000) covering a geographic area of 83,557 square miles. We have 46 general acute hospitals, the majority of which are under 50 beds and none with over 200 beds. These hospitals are performing a vital role in meeting the health needs of the community they serve.

Inasmuch as we are from a rural state with few hospitals, we have been able to watch closely and observe the Medicare Program, which has served a definite need. However, like most programs, there need to be changes in the program to meet the intent of Congress when the bill was passed and signed into law. President Johnson, in signing the legislation into law in 1965, was aware of inherent flaws and made reference to the possible need of legislative amendments. After five years, our hospitals are continuing to work under, in our opinion, unnecessary burdens and problems as pertains to this program.

Our hospitals are charged with the responsibility of delivering health services to Idaho citizens in as efficient a manner as possible and still provide the necessary and needed care—to all patients not just one segment. This includes the Medicare patients. Our hospitals do not classify patients, they provide service for those in need. This is our role and our function and to do otherwise would be morally and ethically wrong. To fulfill this role we must be ever alert and aware of ways to improve. We feel we are improving patient care through our management engineering program (see exhibit A), consolidation of services, sharing of personnel, group insurance programs, and others. Hopefully, very shortly our Association will announce a group purchasing program. The engineerring program, shared services, etc., are examples of voluntary programs undertaken by hospitals to improve care and reduce costs. These cost reductions will simply reduce the reimbursement to the Medicare provider through the present reimbursement formula. An incentive for cost reduction is lacking. We are sure that with the spirit of cooperation that prevails among hospital administrators, medical staffs and boards of trustees of our hospitals that a continuing emphasis will be placed on cost controls and services. However, we must be alert and conscious of our role at all times and make sure that the community needs are met in providing the necessary services.

Our hospital trustees, men and women, from various walks of life, are striving to maintain an adequate level of care under awesome problems. These men and women must approve or disapprove a new needed service knowing full well that Medicare might not contribute toward the funding because it does not adhere to a formula devised by men of integrity who are attempting to administer a law, but not close enough to the local situation to fully understand the problem.

We are pleased to have been asked to appear before you today to inform you of the problems which we face in attempting to work with government to provide a service to a large segment of our population. There are many problems which we feel can be solved to make the program more workable. We will present to you the ones which in our opinion are the most pressing and in need of immediate attention by this committee and the Social Security Administration.

As was previously mentioned, there are 46 general hospitals in Idaho, 23 of which are receiving less than billed charges. The reason for the other 23 to receive billed charges is due in most cases to receiving a subsidy from local government which permits them to provide services at less than cost. Is the taxpayer and patient again paying the costs not properly paid by Medicare? In a few cases the hospital sustained a loss on the operation thus creating a situation whereby Medicare's interim rate of payments is 100% of charges.

A general hospital is a facility to care for patients—not a geriatric center, an OB-Gyn center, etc., and if it were desirable to have only specialty hospitals, in our opinion this is not desirable, they would not be practical in rural Idaho or rural America.

Rural America is not industrialized; therefore, fewer of its citizens are afforded the opportunity of purchasing group health insurance. Therefore, the bad debts of rural hospitals are generally much higher than in urban areas, and with our hospitals having to discount Medicare, this simply increases our write-offs which adds an increased burden to those paying billed charges. What is the reasoning behind SSA not participating in bad debts other than for Medicare patients? If this reason applied to all third party payers and patients who pay cash—then whose responsibility is it to pick up bad debts? Should taxpayers pay school taxes if they have no children in school? If this attitude prevailed in all tax programs, we can see endless problems. Thus, why is this concept forced on our nation's hospitals?

Medicare does not make any provision for debt retirement, except through the payment of interest and depreciation. Since generally debt is amortized over a shorter period of time than an asset is depreciated, the amount of funds needed to amortize the debt must be paid by non-Medicare patients. Is this proper? If a hospital's patient load was all Medicare patients, under the above cited provision, when a hospital building is no longer usable, the hospital will be out of business. Hospitals, like other businesses, must save for the future or "dry up and wither on the vine."

We are aware that Congress is concerned with the cost of health care and primarily the cost of Medicare. We share your concern. However, we do not believe it was your intent to pay for less than cost when you passed the Medicare law.

Our recommendation for a solution to this issue is to permit payment on a prospective basis rather than retrospective and adhere to the American Hospital Association's "Statement on the Financial Requirements of Health Care Institutions and Services." However, we urge extreme caution and deliberation prior to changing to the prospective basis inasmuch as there are disadvantages to such a manner of payment. The current Medicare formula is more equitable to the governmental and proprietary hospital. It is detrimental to the voluntary non-profit hospital such as church-related and community. If the existing regulations continue as related to payment, the non-profit hospital will be "squeezed out" or they will of necessity have to eliminate their Medicare contracts because it is unfair for the hospital to continue to receive less than cost which forces the administration to raise the charges to the non-Medicare patient.

We also recommend that the patient be required to pay a percentage of his total bill. This could bring about a dramatic impact on utilization, the periodic arbitrary regulatory adjustments would be obviated except for possible adjustments in percentage figures if needed, and tremendous administrative costs could be eliminated. This would eliminate the injustice to our other patients.

The Part A and B division should be changed. One suggested solution is to place all hospital related institutional-type care under Part A and all non-hospital

and institutional professional care under Part B. If this were changed, we feel some of the problems would disappear.

The provision relating to the spell of illness is not only troublesome for the hospitals and fiscal intermediary but confusing to the patient. If the above suggested changes were made—having the patient pay a percentage of the bill—then the spell of illness feature could be eliminated and undoubtedly this change would eliminate many problems for the hospitals and much heartache for the patient.

We suggest a change in the printed materials which are being circulated to the public. Much of the information states that the patient is entitled to certain coverage, when in fact the patient is entitled to coverage only if he or she meets certain requirements.

One of the most dramatic problems is in the area of utilization review. How can there be effective utilization review in a community hospital with one, two or three physicians practicing in the community? We believe that utilizaton review is controlled by the community itself. We suggest utilization review be eliminated when there are so few physicians.

Our rural hospitals have not experienced a rapid change in the length of stay of their patients. The length of stay in a rural hospital is only slightly higher today than it was before Medicare and the cause of this increase is due to new life-saving services such as coronary care units which require longer than average stays. (In 1969 the average length of stay in Idaho was 7.5 days; the national average was 8.4.) We feel that the fiscal intermediary could spot check hospitals and if the length of stay is excessive, then offiicals of the intermediary, hospitals and physicians could informally discuss the problem.

Some of our hospitals are experiencing problems where Medicare disallows a claim or disallows it after a certain period of time. This is unrealistic and unfair to the hospital and patient. The hospital does not admit or discharge a patient, it provides a service upon the orders of a physician. However, on a number of occasions, hospital bills are disallowed because on someone's or some committee's advice after reviewing the case on paper hundreds of miles from the hospital, the service is deemed necessary.

Examples of the above problem could be given but time does not permit me to go into details of individual cases. Is it right that a hospital be denied payment in these cases? Why should the hospital be penalized? We are convinced that most persons do not want to be hospitalized and are anxious to be discharged as soon as possible.

One of the most costly items concerned with Medicare is the paper work and the duplication of audits. It has been reported that the Federal Government paid, in 1968, approximately 80 million dollars to independent auditing firms to audit the hospitals for Medicare. It is our understanding this is in addition to the audits on selected hospitals by staff of SSA and GAO (Government Accounting Office) to determine if the independent auditor has done his job in addition to the audit or accounting check performed by the fiscal intermediary. What is the real cost of the Medicare audit?

In addition to the audits mentioned above, the hospital has an audit performed by an independent auditing firm and in many cases the firm which does the Medicare audit does the independent audit for the hospitals. This duplication is a gross waste of taxpayer's and patient dollars. One solution is that SSA accepts the audit by the hospital's independent audit with modifications, if deemed necessary, to meet specific Medicare requirements.

The present cost reporting requirements impose an unnecessary administrative burden on small providers in rural areas. This burden is expressed in both staff time and direct expense, such as increased fees resulting from consultation and preparation of reports by outside auditors. One administrator from a 30-bed hospital in Idaho reported that the charge made by an outside auditor to prepare the required Medicare report was in excess of $6,000. The cost report as required by regulations generally cannot be developed in the small hospital by existing staff. The business office staffs do not generally have the capabilities; therefore, must rely on expensive professionals from auditing firms. I was told recently that hospitals shouldn't concern themselves with this cost because it was a reimbursable expense under Medicare. This is gross misrepresentation. For example, in the hospital cited, if a third of the patients were Medicare, then the Medicare program would reimburse only $2,000, not the full $6,000. The remaining $4,000 would be paid by the non-Medicare patient. The complicated cost report does nothing for the non-Medicare patient. If the Medicare philosophy is to

pay for only services used by Medicare patients, then why doesn't the program pay all costs which are inflated due to unreasonable requirements that serve no useful purpose to non-Medicare patients?

The present cost reporting requirements impose an unnecessary administrative burden on small providers in a rural area. This burden is expressed in both staff time and direct expense such as increased fees resulting from consultation and preparation of reports by outside auditors. Under Medicare, small providers should be allowed to recover program costs on the basis of an average cost per diem. If SSA would accept average per diem, then reporting on the basis of costfinding would not serve any meaningful purpose in determining overall reimbursement.

In Idaho there are eight combined hospital and extended care facilities, each of which has a single administrator. Our experience indicates that the application of Medicare costfinding procedures results in a disproportionate amount of costs being apportioned to the ECF where Medicare utilization is normally low. The effect of this disproportionate allocation is to reduce allowable Medicare expenses in the hospital. We recommend that the Medicare program publish acceptable alternative costfinding procedures that alleviate this problem.

Other forms of paper work such as the Medicare log and admitting and billing forms are costly and serve no major purpose. One hospital in Idaho has employed a full-time clerk to maintain the Medicare log; however, this is not totally reimbursable under Medicare. We suggest a simplification such as those used by Blue Cross or commercial insurance companies, or possibly a simple credit card approach. The billing forms required for inpatient and physician should be combined.

SSA has a committee of hospital consultants to advise on forms and procedures This committee should be expanded to have representation of hospital personnel from hospitals of under 100 beds. Many of the recommendations of this committee have not been acted upon; however, those which have been accepted have resulted in reduced administrative time, improved cash flow which keeps charges down. The value of this committee should be recognized and its recommendations acted upon where possible.

The rules and regulations as affects certification of providers should be relaxed. A requirement that a registered professional nurse be on duty in the hospital 24 hours a day seems to us a bit unrealistic. If this requirement were carried to its fullest degree, a 600-bed hospital with one R.N. would meet the requirement but a 30-bed hospital not having an R.N. on one shift in a given week, but a nurse on call, would not be in compliance with the regulations. Granted, this is an extreme example and no hospital by choice does not cover all shifts with an experienced R.N. However, at times the small hospital cannot get a qualified R.N. Should that hospital be closed under that situation when the closest available hospital is 50 or 100 miles away, and in many cases over mountain roads, and during the winter these roads are icy or snow-packed? The point we are attempting to make is that factors and situations are different from area to area and rural vs. urban. Shouldn't these factors be considered when regulations are established? Must a rural hospital in a farming community of Idaho adhere to the same regulations as a large hospital in New York City—is this realistic? Is the quality of care judged by adherence to unrealistic regulations or is it judged by the type of care given?

To be fair and equitable to the providers, HEW should be required to pay 100% of all direct costs due to Medicare patients where clearly identifiable before developing the reimbursement formula.

During the last fiscal year, a 150-bed hospital in Idaho had contractual adjustments for Medicare of $119,787. The total patient days at the hospital during the same period was 48,429 of which 16,374 were Medicare. The cost of the Medicare write-offs equaled approximately $4 per patient day for the non-Medicare patient. In other words, the non-Medicare patient had to pay on top of an already high hospital bill $4 per day to cover the Medicare loss. If the public were fully aware of this inflated hospital bill, I wonder what would happen?

Our hospitals and physicians resent the negative philosophy regarding certification and re-certification of the Medicare patient. In basic terms, this philosophy states hospitals and physicians are going to "cheat" the program; therefore, we must put a "watch dog" out in the form of the certification and re-certification requirements. In most cases, this requirement is costly and unnecessary. There are standards which have been developed on average stays. Why can't the fiscal intermediary watch length of stays and should a provider abuse it, appropriate action be taken? Why penalize all providers for the unscrupulous acts of a few?

The Medicare officials refuse to pay for a private room unless medically needed. If a hospital has no semi-private rooms available and a Medicare patient has to be placed in a private room, Medicare will not pay the difference between the private and semi-private. If I go to a hotel and ask for a single room, none of which are available, and I have to take a deluxe room, I am required to pay the difference. Why should hospitals be required to discount the Medicare bill even further when this occurs?

In summary, we would like to re-emphasize to you that the Medicare law has been a benefit to many, that we are as concerned as you with the cost of health care and that we in the health care industry are attempting to control costs in many areas. We feel there are many ways in which HEW can reduce costs in the Medicare program, a few of which have been raised in this testimony: duplicate audits, paper work, certification requirements, etc., and some not elaborated on such as tremendous staffs in the central office of SSA and regional offices which are required to enforce regulations, act as consultants, etc.

The providers accepted Medicare in the beginning in good faith and have gone beyond the call of duty to make it work. These same providers are, after 5 years, eager to continue their efforts to help make the system work. We trust that you will work with us so that our system can continue to function.

Exhibit A

Management Engineering Program

The Hospital Associations of Idaho, Oregon and Washington have gone into a cooperative program to provide management engineering to the hospitals in the three states. This program was made possible through a sizable grant from the W. K. Kellogg Foundation and the Blue Cross plans in the three states.

The three states have contracted with Battelle Northwest of Richland, Washington, to conduct the program. It is estimated that the program will be implemented in approximately 160 hospitals in the three states within three years. Annual savings per institution is estimated at 10% of payroll.

Additional Information Presented by the Idaho Hospital Association

BUSINESS OFFICE OPERATIONS—INPATIENTS

The operations of the business office can be defined briefly as the admitting function, accumulation of patient charges and the billing for patient services.

Prior to Medicare *this form* was used to capture necessary admitting information, accumulate the patients' charges, and be used to bill for services.

Now we have Medicare. In addition to *this form*, this many more are required in order to bill for various circumstances under the Medicare program. In addition, if all of the hospital based specialists billed for their services, it would create this many additional forms. I believe that one form should be developed which would be acceptable as a hospital record of charges to the patient and likewise acceptable as a billing document for Medicare.

Outpatient services by their very nature deal in high volumes and relatively low dollar amounts. The administrative costs involved with billing for these services should be kept to a minimum. I submit that rather than using these documents: (1) a hospital record, (2) a separate form used to bill the Medicare program, a new approach should be considered.

A new approach to consider would be the credit card approach used by the petroleum industry for years. The plastic embossed card could be used to capture pertinent beneficiary data without typing, and the charge could be categorically recorded. This same system could be used to address forms necessary for inpatient admission notice.

BUSINESS OFFICE OPERATIONS—OUTPATIENTS

Outpatient services should be encouraged. For this to be accomplished, a change in the present deductible and coinsurance mechanism should be made. Immediately you ask why? Let me illustrate through example:

A Medicare patient arrives at the hospital on doctors orders, has a C.B.C.—$6; Chest X-ray—$10; and electrocardiogram—$20—Total bill—$36. If he has not

met his deductible, the patient would pay the $36. Generally he does not know if it has been met or not. If he met all but $6 of his $50 deductible, he would pay as follows:

Remaining on deductible		$6.00
20 percent coinsurance based on charges		6.00
Intermediary should pay the professional component:		
Laboratory	$1.50	
X-ray	2.60	
EKG	5.00	9.10
Total		21.10
Balance of charge reimbursed at 83 percent (which is one Idaho hospital's current ratio of costs to charges)		12.37
Absorbed by the hospital		2.53

Since the patient pays charges and final settlement is based on cost, the hospital finds itself in the position of being overpaid, and in need of repaying the intermediary. Add to this the fact the intermediary may reimburse at 100% of charges and the repay becomes sizable. The repay for 1969 at that hospital was $10,552.

	Costs	Payments
Professional component	$9.10	$9.10
Other at 83 percent times (26.90)	22.33	12.37
By patient		12.00
Total	31.43	33.47

Since the patient generally is unaware of the status of his deductible, I suggest that the deductible be eliminated. Since it is confusing, some hospitals request total payment as services are rendered and let the intermediary calculate the proper deductible and coinsurance as well as refund the patient any over payment. I believe a straight coinsurance approach to outpatient services would make the program more easily understood by patient, hospital and intermediary.

REIMBURSEMENT

Reimbursement on a prospective basis rather than a retrospective basis is highly desirable. This approach should be coupled with payments to hospitals based on their financial needs and not on expired costs. Payments for financial needs implies that all patients share equally in financing the needs of the hospital. It says that if telephones are in every room the self-pay patient as well as the Medicare patient pays for this service.

Prospective reimbursement requires advance planning based upon the financial needs of the hospital. In developing the financial needs, the community health needs must be taken into account. Once a budget has been approved as the basis for reimbursement, certainly an incentive exists for operating a hospital at below budgeted costs. The actual operating costs for the period can then be taken into account during the budget negotiations for the next period. An incentive for cost reduction currently does not exist.

Once budgeted needs have been approved and rates established, all patients would pay the same charges for services. This system should eliminate duplicate areas of accounting which are of necessity currently practiced. This would also relate to a simplified billing system.

The present reimbursement calculations have created a new specialist. The preparation of the report takes from two to four weeks to complete if all necessary data is readily available. The controller of a hospital must continually sift all Medicare data in hopes that he can keep abreast of the charges.

For example: Effective April 1, 1968, full reasonable charges for radiology and pathology services furnished by physicians to inpatients of participating hospitals became payable under Part B. These charges to Medicare patients had to be calculated and added to the final amount due the hospital or subtracted from the amount due the Health Insurance Program. Reimbursement forms were not made available indicating this calculation until September, 1969.

Our hospital had filed two statements of reimbursable costs by that date. With the hospital's fiscal year ending May 31, only one month could be taken advantage of for the first year. The second year a full year was available. This provided the hospital with $1,808 and $12,531 respectively as direct reimbursement over and above cost.

I am positive that many hospitals in the country have not taken advantage of this change.

AUDITS

Medicare audits are performed some six months after a hospital's fiscal year end. Complete and final agreement on the results of the audit may take an additional six months or more. This means that the reimbursable percentage as calculated on the ratio of costs to charges may be in error and result in sizable over-payment or under-payment to a provider.

Reconciliation of charges to Medicare patients between the provider and intermediary many times is a tedious time-consuming task. The Medicare audit disrupts hospital routines and requires the time of accounting personnel that could be better spent working on ways to contain rising costs.

The costs of audits must be extremely high. Yet if Medicare would reimburse fully for the hospital manhours devoted exclusively to these audits the cost would probably double.

Audits are complicated by late decisions and retroactive rulings. An example might be the 8½% cost differential for nursing care is to be retroactive to July 1, 1969.

If accelerated depreciation is eliminated, perhaps it should be effective July 1, 1966. The logic could be if it isn't necessary now, how could it have been at the beginning of the Medicare Program.

MEDICAID

Medicare is difficult, but Medicaid is unbelievable. The amount of information available to hospitals on Medicaid is scanty. Reimbursement varies from state to state. Idaho of course requires a reimbursable cost statement. They have had two on file from St. Alphonsus Hospital since December 30, 1969, the date requested for filing. Neither has been audited as yet.

States outside Idaho request reimbursable cost statements be filed with them also. However, we make no attempt at accumulating charges to Medicaid patients from other states. The charges are the basis for completion of the report. Regulations related to other states are hard to come by and difficult to interpret. For example:

One state paid the hospital $2,000 on a patient's account. The state's attorney general's office indicates that a judgment will be placed against the hospital if the payment is not refunded. The reason the refund should be made is that the payment was made in error. The patient does not qualify under the "M" or "N" category. What the hell is the "M" or "N" category?

Similar problems related to Medicare apply equally to Medicaid—billing, reimbursement and audit. A single system would be most helpful. Remember there is only one hospital which must divide itself to the many state Medicaid plans, Medicare, Title V, Champus, Vocational Rehabilitation, Crippled Children's Service, etc. These are all government financed programs each with separate rules and regulations. Any consolidation and centralized administrative coordination would be beneficial to the hospitals and the patients they serve.

SUMMARY

I believe the problems touched on today in the business office operations, reimbursement, audit and Medicaid all indicate that the whole approach could use an overhaul. The solutions are not easy. I have offered some ideas today that I feel would be helpful. The power of change rests in your hands.

Senator ANDERSON. We appreciate your statement.

Senator WILLIAMS. May I ask just one question?

Senator ANDERSON. Senator Williams.

Senator WILLIAMS. You showed there the forms that must be filled out for admission of one patient. Do you have an extra set of those which you can leave with the committee?

Mr. ANTON. We can leave this set, Senator.

Senator WILLIAMS. We would appreciate it.

Senator ANDERSON. Senator Fannin?

Senator FANNIN. Are you familiar with the bill I introduced to provide for hospital and medical care through a system of voluntary hospital insurance? I think it would provide for many of the facilities that you mentioned in your statement. I just wondered if you have not seen a copy of this bill, if you would take a copy and then report back to the committee your comments on this proposal.

Mr. HUTCHISON. Senator, we would be very pleased to do that. We have seen the proposal. We have not studied it.*

Senator FANNIN. I realize the problems you have, because I come from a State where the distances are quite similar to yours, and we are very concerned about the certification of minimal standards in the isolated areas where there is a great need for the health facilities. I am sure as we go along, we will discuss the possibility of providing the services for those areas. I realize it would take some changes in our present requirements, but I am vitally interested and I would like to talk to you about it a minute when the hearings are over, about something we have in Arizona which I think will be of assistance to you.

Senator ANDERSON. I want to say that Senator Jordan, who is a very valuable member of this committee, has some questions he wants answered. We are not going to ask you to do this now, but they will be asked this afternoon by the staff, and if you would appear then, we would appreciate it.

We thank you very much for appearing. The Senators must go to the floor now and if you will return this afternoon, the staff will ask Senator Jordan's questions.

The STAFF. There probably will not be any need for anybody to come back this afternoon, if we can finish up now.

Will the Idaho people please stay, if that is convenient?

We have those questions which Senator Jordan wanted asked. Unfortunately he could not be here. Perhaps a couple of minutes of staff questioning now will save your returning later.

First, we have the questions of Senator Jordan.

The Senator wanted you to comment on problems small hospitals have in attempting to administer the medicaid program.

Mr. HUTCHISON. May I refer that to Mr. Anton, who is comptroller of one of our hospitals in Idaho, and I think that he could probably give you more factual information than I could.

Mr. ANTON. Thank you.

One of the problems—I would say the greatest problem—is lack of communication. The administration of the medicaid program in Idaho is administered by personnel who are not thoroughly versed in requirements of medicaid. They do not have sufficient staffs required to audit any medicaid reports that may be filed. They do not have sufficient staffs to offer advice when advice is needed on how to handle a particular situation under the medicaid laws.

It is just extremely difficult. We never know where you stand with them. An example is, our hospital has filed two reimbursable cost reports and has sufficient moneys due back to the hospital—these are 2

*At presstime, August 10, 1970, the comments referred to had not been received by the committee.

years in arrears, and we have not received an audit, nor have we received funds.

Mr. HUTCHISON. Mr. Counsel, if I might make just one other statement:

I think another problem, if you are familiar with the geographical layout of the State of Idaho, we are very close to about four other States which patients from those States come into our hospitals, and with regulations in four other States that are somewhat different from our own, it becomes a little bit difficult at times.

The STAFF. Why are payments for interest and depreciation not sufficient to retire debt?

Mr. HUTCHISON. May I refer this to Mr. Anton again?

The STAFF. Do you think, by the way, that in part, that was answered in the American Hospital Association's testimony? Did you have an opportunity to read that?

Mr. ANTON. Yes.

The STAFF. Is your response essentially the same answer?

Mr. ANTON. It was answered, yes.

The STAFF. Do you want to elaborate on that?

Mr. ANTON. I think I could elaborate by citing an example.

This is an example saying that medicaid patient load running approximately one-third in the hospital and assuming new construction of the facility, which is pretty much our situation right now, a facility, a structural cost of $12 million, which will require a debt of $7 million, and a debt service factor or interest of 11.9 percent. Medicare, under the straightline depreciation, would reimburse the hospital $80,000 a year. Principal payments on this loan during the first year will be $143,000, which really is not too bad that first year, because assuming, again, a third of the patient load is medicare, and relate a third to the payments on the principal.

The STAFF. Is this a commitment you have already made?

Mr. ANTON. Right.

The STAFF. I believe the regulation is being modified to allow accelerated depreciation on commitments made prior to the date of issuance of those regulations. Have you heard of that?

Mr. ANTON. Right. This is a matter of concern, why we would like to talk today, because we just do not know where we stand right today.

Fifteen years from now, when we refinance this debt, we will refinance it at approximately half that amount. We will still be getting $80,000 a year, and assuming the load stays constant, our principal payments at that point will be $590,000. So you can see a third ratio on principal payments in that time are totally inadequate. They are just not meeting the need. This financial need will have to be borne by patients other than medicare patients.

The STAFF. What do you feel are the disadvantages to prospective reimbursement? This is continuing with Senator Jordan's questions.

Mr. HUTCHISON. Sister, could you make some comment?

Sister MOELLER. I can think of two things that might be a problem to small hospitals in Idaho. First of all, prospective reimbursement is going to require some very dignified, sophisticated budgeting procedures. Some of our very small hospitals do not have the type of personnel versed in these types of procedures.

I think something of more concern to us is, who is going to be responsible for looking over the budgets and determining that these will be acceptable? Are they going to be people from our own areas who understand our situations, or is it going to be someone from a distance who is making a judgment on a situation they do not understand? These two points are of concern to us.

The STAFF. In the area of paperwork simplification, how do you foresee simplifying paperwork and medicare log accumulation?

Sister MOELLER. I think I would like to turn this to Chris.

Mr. ANTON. Well, Mr. Hutchison touched on it briefly. That is the idea, perhaps, of utilizing a credit card approach for outpatient billing.

The other area would be, again, to institute a coinsurance, a straight percentage coinsurance, eliminate the deductible so that it would not have to be communicated between the hospital, the intermediary, SSA and back again; arrive at a uniform bill that would be acceptable for use in the hospital by the intermediary and by SSA, which would fill the need of billing at once on one form, and that would be sufficient, rather than having one bill for the institution and a separate bill or form for each exception that may relate to a particular category of stay.

The STAFF. Senator Jordan wanted you to elaborate on standards of performance, such as utilization review and nursing requirements, as they affect the small rural hospital. You did go into that rather extensively. Did you want to add anything to your statement on that?

Mr. HUTCHISON. Sister?

Sister MOELLER. I think the only thing we want to say is that we do not want to go on record as being against any standard for the small rural hospital. We feel that the small rural hospital needs standards, but we do not feel it is justified in making the 30-bed hospital adhere to the same standards as the 300- or the 3,000-bed hospital. This we feel is unrealistic.

The STAFF. How about the 10-bed hospital?

Sister MOELLER. The 10-bed hospital falls in the category with the 30-bed hospital.

The STAFF. Would you comment on your position relative to medicare forcing patients into acute-care facilities?

Sister MOELLER. We definitely feel there is no incentive to the hospital or the institution, nor to the patient, to get out of the acute-care facility.

We feel the only way to reduce hospital costs is to get patients out of hospitals. Right now we are investigating a program within our own institution to cut down on the length of stay to the acute-care patient; to get him out of the hospital, in other words.

However, we are almost afraid to go into this, because we are not going to know until after 1 year of operation whether or not we are going to suffer financially—not only after 1 year of operation; after perhaps 2 years, because it will be 1 year of operation and then another 6 months to a year before all the auditing and discussions between the intermediary and provider are finished, to get the final settlement and our reimbursement.

So we feel it would be an incentive to us to get these patients out and an incentive to the patient.

The STAFF. That completes Senator Jordan's questions. We have some additional questions for you.

How many of your member hospitals fail to provide around-the-clock nursing coverage?

Mr. HUTCHINSON. To my knowledge, none.

If I may clarify that, there could be one or two that maybe on a Saturday night or a Sunday night or a Monday night, they cannot cover one shift because the nurse is ill and cannot come to work.

The STAFF. Those are the shifts when people do not get sick?

Mr. HUTCHINSON. Yes.

The STAFF. Can an institution run without round-the-clock nursing coverage be properly termed a "hospital"?

Mr. HUTCHINSON. In my opinion, yes, because the regulation simply states that there must be a registered professional nurse. It does not state the competence of that individual and, in many cases, if you have a nurse on call that can be at the hospital on a moment's notice, she might, in this situation, be much better than an incompetent nurse just to meet regulations. Sister might like to elaborate on this, also.

Sister MOELLER. I think that one thing we overlook is in our small rural hospitals they are not taking care of the same level of patients as in the larger hospitals. Many of the patients there do not require the same intensive care as is required, say, in the larger hospitals, where the patients are referred when they have more serious types of conditions. In other words, they care for the patient that has, shall I say, a more minor type of illness.

The STAFF. Well, there is some surgery done occasionally.

Would you favor a possible change in the law to set up an additional classification of facilities? For example, in rural areas where the institution is the only facility for, say, 40 or 50 miles, that it not be required to meet the standards of a hospital unless it calls itself a hospital. In essence, it be recognized as a rural health center, and that it be reimbursed and qualified on the basis of the services which it is equipped to provide—no more, no less. There is no major surgery, that kind of thing, if it is not geared for that. Would you be interested in exploring that? The staff has been exploring that.

Mr. HUTCHINSON. I think that we must explore all areas in which we feel that there could be some reductions in cost for the patient, medicare, and so on. If this is an area that could provide a service to a group of patients, then I think it is worthy of exploring.

But I would caution anyone to consider a lesser degree facility in an area, say Salmon, Idaho, which is 100 miles, almost, from any other facility. In other words, they do have to perform some surgery, they have to deliver babies, and so on. So if we were to classify that hospital as less than a hospital, but yet have them perform that type of service, then we are doing a disservice for that type of community.

I am rambling a little bit, but I think——

The STAFF. Assuming the facility were equipped to perform surgery, there is no reason why it would not be approved for that.

On the other hand, so there is no misapprehension, when we say we are considering this, it was not in the context of permitting understaffing in substandard and marginal facilities in an area where you have alternatives.

Mr. HUTCHINSON. For example, if I may just comment on this briefly, we have thought in our State of helicopters—how can we maybe station helicopters in an area that might cost $300,000, and in lieu of that, a

hospital would cost $600,000 or $700,000? Can this type of service be worked out? We have discussed this also.

The STAFF. Well, just so you do not think the Finance Committee staff is entirely negative, for smaller hospitals, and those with low-average medicare occupancy, would you favor or be friendly toward a reimbursement approach which accepted charges up to specified limits based upon sample audited costs for comparable services in comparable facilities in the same area? That is, if you have other facilities of a larger size, essentially comparable in terms of the range of service in the area, which have higher occupancy levels—if you said, for example, that institutions with average medicare occupancy of 10 percent or less, or 20 percent or less, could bill on the basis of charges up to a maximum, a maximum established on a cost-related basis for those hospitals or institutions which had sufficient occupancy to justify requiring costs reimbursement?

Mr. HUTCHISON. I would like to refer that to Sister and Chris, because Sister is on the board of a 10-bed hospital.

The STAFF. It seems that every time we discuss simplification, it comes out complicated.

Sister MOELLER. Initially, I would say that this sounds like—I do not understand it to its fullest extent, but it sounds like something we could look at, simply because if we look at the costs in these small hospitals, certainly a 10-bed hospital with a low occupancy of medicare patients, their costs are relatively low.

They could not be seriously hurt by this. And I think it is a fair way of establishing reimbursement for these hospitals.

The STAFF. I know that the chairman and the other members of the subcommittee would want me to thank you for coming.

We have just a few more questions for the Federation of American Hospitals.

In their testimony here in April, the Blue Cross Association agreed with the staff that an implicit conflict of interest exists, where a physician has an ownership interest in a health care facility in which he admits and orders services for his patients. In general, do you believe that such an implicit conflict of interest is present, in those situations?

STATEMENT OF SHERWIN L. MEMEL—Resumed

Mr. MEMEL. No.

The STAFF. How many of your member institutions are owned, at least in part, by physicians who place their patients in the facility or facilities in which they have an investment?

Mr. MEMEL. My best answer to that at this time would be a substantial number. I cannot tell you whether it would be a majority or not.

The STAFF. A number of beneficiaries have complained to the committee that their physicians are routinely charging a separate hospital admission fee—not a hospital cost, but in terms of the physician billing for the service. Have you encountered this type of charge?

Mr. MEMEL. No.

The STAFF. In your statement, you argue that at least one member of a utilization review committee be permitted to have an ownership interest in the facility. Why should that be permitted where nonowner

committee members are available or other review arrangements can be made?

Mr. MEMEL. Normally an owner who has been acquainted with a hospital for a substantial period of time can bring to the committee knowledge about the hospital, its history, its operational problems, its economic implications or the equipment, a variety of things that the ordinary staff physician who has not had the opportunity of serving on the board and has no ownership interest cannot bring.

The STAFF. What does that have to do with the patient's condition and his capacity for transfer to a limited care facility or the duration of his stay?

Mr. MEMEL. I believe the function of utilization review substantially exceeds that definition which you have just given to it. I believe that utilization review committees have to get into the question of adequacy of equipment; have to get into many ancillary questions above and beyond a purely limited or technical question. That is why they have related ancillary personnel also serving on utilization review committees who are not physicians.

The STAFF. Well, we sort of were under the impression—it must be a misunderstanding—that the function of a utilization review committee was to determine that the patient was in the right place at the right time, getting the right care. What has that to do with the owner's interest in the facility or the quality of equipment in a hospital, beyond the fact that you can determine that the institution was unable to provide necessary care, is kind of difficult to follow.

Mr. MEMEL. Well, I believe that the three broad general guidelines that you outlined encompassed the things that I outlined earlier and that a material contribution can be made by the owner.

Conversely, I see no reason for excluding a qualified individual from serving on a utilization review committee merely because he is an owner and merely because there have been accusations or claims that the potential for conflict exists.

The STAFF. There have been substantial cases.

Mr. MEMEL. I understand that evidence is alleged to exist to substantiate these cases. I have not seen that evidence. I have not heard whether the people in those cases have had an opportunity to rebut the evidence.

The STAFF. They have been invited in, but they do not come in.

Mr. MEMEL. Well, I can understand possibly the reason they do not come in, in some cases, and it would not have to do, necessarily, with their guilt or innocence.

I am not saying that you cannot substantiate these cases. I will not be naive enough to say that there are not abuses, and I will not be naive enough to say there have not been situations where the potential of conflict is taken advantage of. I just do not like broad, sweeping generalizations. I happen to be naive enough to believe that most of the physicians in this program are honest. I think the program has been perhaps more misused than abused. I think there is a lot of fault in the program and circumstances.

The STAFF. In its report the staff stated its belief that many of the physicians who did have an ownership interest were undoubtedly not motivated by that, but in all of such situations there was an implicit conflict of interest in terms of ordering care and services in

a facility in which they had an economic interest and where a return on their investment was directly related to the volume of business done in that facility. You say you do not feel there is an implicit conflict of interest?

Mr. MEMEL. That is not the question I answered. You asked me it somewhat differently. In other words, if you are asking me do I believe in each instance is there an implicit conflict of interest, meaning one existing, I say "No."

If you ask me is there a potential for conflict in a situation where a physician has an ownership interest in a facility, I would have to agree that there is a potential. However, there is a potential for conflict in so many areas of human life, including the practice of law, including the practice of office medicine, that if you carry your potential argument to its logical extreme, we would have to change our entire system of government, I am afraid. Therefore, the mere existence of a potential means nothing to me unless there is established that there is such a substantial abuse of this by demonstrated evidence under the process of due process, that justification for exclusion of ownership can be supported.

The STAFF. You are aware that a provision of the new House bill, which was passed last week, with respect to unreasonable costs—that is, where the patient is responsible for payment of costs above a certain level—that the Ways and Means Committee and the House agreed that the patient would be responsible for those excessive costs except in a facility where the admitting physician was an owner of the facility. Did they have the benefit of your views on this point?

Mr. MEMEL. Interestingly enough, there is no explanation of their comment in the committee report. The staff apparently does not know how it got there. It never came up here in the course of the hearings, to my knowledge.

Since we were asked to direct our testimony today primarily to the Senate staff report, we did not comment on that bill. We will have something to say about it when and if we do have a chance.

The STAFF. Thank you.

In accordance with the instructions of the chairman, the subcommittee will meet tomorrow morning at 10 o'clock.

(Thereupon, at 12:05 p.m., the hearing recessed until Wednesday, May 27, 1970, at 10 a.m.)

MEDICARE AND MEDICAID

WEDNESDAY, MAY 27, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Hon. Clinton P. Anderson (chairman) presiding.

Present: Senators Anderson, Ribicoff, and Williams of Delaware.

Senator ANDERSON. Our first witness this morning is the Arkansas Nursing Home Association, Mr. Charles Stewart, and several other nursing organizations.

STATEMENT OF CHARLES A. STEWART, EXECUTIVE DIRECTOR, ARKANSAS NURSING HOME ASSOCIATION; ACCOMPANIED BY JOHN WHEELER, PRESIDENT OF OHIO NURSING HOME ASSOCIATION; J. M. POWELL, PRESIDENT OF THE LOUISIANA NURSING HOME ASSOCIATION; AND GEORGE McKENZIE, WISCONSIN NURSING HOME ASSOCIATION

Mr. STEWART. Mr. Chairman, I am Charles A. Stewart, executive director of the Arkansas Nursing Home Association. I have with me Mr. J. M. Powell, of Louisiana; John Wheeler, from Ohio; and George McKenzie, from the State of Wisconsin.

Mr. Chairman, members of the committee, I have introduced myself and my colleagues. My appearance here today is in behalf of four State nursing home associations—Arkansas, Louisiana, Ohio, and Wisconsin.

With your permission, I would like to make a brief introductory statement in behalf of these four State associations which would be followed by brief presentations by Mr. Wheeler and Mr. Powell. I feel certain we will be well within the 15 minutes allotted us.

The four State associations for which I speak are grateful for the thoughtful, perceptive, and sensible manner in which the problems and issues associated with the medicare and medicaid programs have been analyzed and discussed by the staff of the Senate Finance Committee. We feel, and we know that leaders in other State associations share our feeling, that this report and its implementation can mark a major turning point in the administration of these two monolithic health care programs. A turning point which we believe will result in improved delivery of services to patients, significantly better control of costs, greater equity in the payment of

providers for services rendered, and an end to abuses which have tended to mar the otherwise good and honest performance of the vast majority of providers of health services under the program.

Disclosures and undisclosed illegal kickback arrangements and conflicts of interest among and between the providers of health service under the medicare and medicaid programs have become as frequent and routine as the delivery of the daily newspaper. Let me assure you, the members of this committee, that there are many responsible people in the nursing home profession who are revolted, angry and distressed that professionals, whether institutional owners, or administrators, nurses, pharmacists, or whatever, continue to seek out and discover means of making illegal or immoral gains from these programs. The means are available to put an end to such piracy, and I sincerely hope that those who are exposed pay the full and criminal penalty which their infamy deserves.

We have a number of suggestions to offer today which we feel complement the findings and recommendations of the staff report. Our concern, as is yours, is that patients be provided the proper care their conditions warrant and that this care be provided without excessive costs. May I give an example of our thinking? Medicare and medicaid regulations require that an ECF and/or a skilled nursing home must have a consultant dietitian, a consultant social worker, and a consultant medical records librarian. In Arkansas, the State welfare department already has social workers in nursing homes and the State health department furnishes dietitians and medical records personnel who regularly assist participating facilities in these functions. Yet the ECF and the skilled nursing home are required by law to spend taxpayers' money to hire additional consultants to assist in the performance of these same functions. I believe you will agree that this is an unnecessary and costly duplication and further drains the limited supply of such highly specialized personnel. We would recommend that Arkansas, and other States providing similar services, be permitted the option in their State plans of exempting participating facilities from duplicating these and similar consulting services.

Mr. Wheeler and Mr. Powell have additional suggestions to offer this committee, and our time is limited. It is the contention of the four nursing home associations which we are representing that good nursing homes can meet the challenge of working with the complex regulations which have created a complex system of delivery of services. But we feel that too often bureaucracy has created the complexities simply for the sake of complexity. The example I cited, concerning consultant services, is a relatively simple and direct method of meeting the complex and diverse professional service needs of the participating facilities. We feel that the recommendations of the staff, in effect, call for a move toward greater simplicity in the regulation and administration of the two programs. We urge the committee to move in that direction.

Now, may I present Mr. Wheeler.

Mr. Wheeler. Mr. Chairman, members of the Senate Finance Committee, your committee, through its knowledgeable and tireless staff, has produced a landmark document in the staff report dated February 9, 1970. It is an extremely fair, competent, and penetrating analysis of the failures and disappointments experienced in the delivery of

complex and diverse health services to a complex and diverse cross-section of our people—the beneficiaries of the medicare and medicaid programs. No part of the delivery system escapes its share of the blame—the bureaucracy, which has failed to follow the mandates of the Congress; the States, some of which have failed to provide adequate funding; the fiscal intermediaries, some of whom have failed to administer their part of the program fairly and efficiently; and the providers of health services—physicians, hospitals, nursing homes, and others—some of whom have failed to live up to their contracts and others of whom have abused their contracts for purposes of financial gain. We are in substantial agreement with the conclusions and recommendations of the staff report. We believe the report is an honest appraisal and merits the kind of careful consideration this committee will undoubtedly give at the conclusion of these hearings.

Senator ANDERSON. I am glad to hear your praise of the staff. They have done a fine job and we appreciate your comments.

Mr. WHEELER. Thank you, Mr. Chairman.

We would like to comment on several matters reviewed in the staff report and suggest possible steps for implementing the reforms so clearly needed. First, the matter of reimbursement under title XVIII—medicare. We are delighted to find the staff study has confirmed the fact which every responsible nursing home organization and individual nursing home administrator has stated repeatedly—the "reasonable cost" formula is inflationary, unfair, and unmanagable, and promotes inefficiency and waste. We commend the staff efforts to develop an alternative method of payment, one which more nearly parallels the traditional competitive enterprise cost- and price-setting mechanism. We, of course, do not know the precise form the staff recommendation will take and therefore offer some suggestions which we feel should be given consideration in developing a new reimbursement system. We suggest that there are, in fact, three distinct types of ECF's participating in the medicare program, not in terms of the standards being met and services supplied, but rather in terms of degree of participation in the program.

We define these three types as the major provider, the substantial provider, and the casual provider. We believe that these three types of providers can be readily identified by their patient loads, and that the method of payment to each type of provider can and should vary.

The major provider, in our view, is the facility which has an average annual occupancy of medicare patients somewhere in excess of 50 percent of total capacity. This type of facility has geared its operations and its resultant cash flows to the medicare program. We believe that some form of cost-finding mechanism is desirable and necessary in order to assure reasonable limitations on the average daily benefit to be paid. But such a facility should expect to realize a reasonable return over and above the actual costs. As indicated in the staff report, incentives for efficiency and economy should be given due consideration in rate setting for such facilities.

The substantial provider, as we see it, is the facility which has an average annual occupancy of medicare patients falling somewhere between 20 and 50 percent of total capacity. Because this type of facility relies heavily on private pay and other types of patients, its total cash flow is substantially less affected by payments for services

rendered to medicare patients. Because its daily charges to private-pay and other-than-medicare patients are established as the result of competitive factors in the community and region, it would seem appropriate to accept, as the medicare daily rate, the bona fide charges made to private patients in such a facility. It would be necessary, however, to set such a prospective rate in advance, on a fixed occupancy basis, in order to protect the Government for a specific contractual period. Such a prospective rate could be arrived at annually, based upon the experience of the preceding year, reasonably related to the cost of providing care and limited by the combined average payment made to major providers in the area.

The casual provider, we suggest, is the ECF with an average annual occupancy of 20 percent or less of medicare patients. Because this type of provider relies upon other than medicare patients for virtually all of its operating cash flow, its rate structure is more closely attuned to the competitive, free enterprise factors at work in its community and region. We believe that such providers should be compensated for the relatively small numbers of medicare patients, based on their bona fide average daily charges, limited by the combined average payment made to substantial providers in the area.

Implicit in these suggestions is our view that the costly and cumbersome recordkeeping, and subsequent expensive and time-consuming audit, be eliminated. The staff report very aptly refers to this aspect of the current formula and its application as the "audit overkill," a phrase with which we heartily concur.

We believe recognition that there are, in fact, the three types of ECF's we have outlined is of the utmost importance to the future stability of the title XVIII program. The casual provider does not now account for large numbers of ECF patients, largely because of the complex, costly, and unrewarding cost-reimbursement formula. Given the opportunity to provide services to medicare patients at reimbursement levels which have proven competitive and sound in the normal operation of the facility, the role of the casual provider can be expected to accelerate.

While the substantial providers are now carrying a relatively large number of medicare patients, the significant savings in cost finding and recordkeeping, and the substantial savings in followup audit, will assure rates charged and paid for medicare patients are consistent with the rates paid by private pay and other users of the facility.

The major providers, those who have made a substantial commitment to filling the need for ECF beds, can be expected to respond to the "incentive" aspects of the proposed staff reimbursement plan, achieving economies wherever possible. It would be required that all facilities in all categories be in full compliance with regulations pertaining to program operational standards. Minor deficiencies would result in a reduction by a percent of the applicable base of payment.

DISTINCT PART CERTIFICATION

We strongly endorse the staff comments concerning the problems which have arisen in "distinct part" certification of ECF beds. Lack of clarity on the part of the Social Security Administration in defining and limiting the specific area to be certified is the root of the

problem. This vagueness provided the unscrupulous with a blank check, by enabling manipulation of bed vacancies so as to inflate medicare costs. The staff proposal that the "distinct part" provisions be administratively modified so as to define a physically and clearly distinct section of the facility, complete with separate nursing station and recordkeeping, is a good one. Social Security should move promptly to close the existing loophole. It will, we feel, pose no hardship for the vast majority of facilities which have conscientiously and honestly tried to comply with an ineptly worded and poorly managed regulation. And, we believe, the reimbursement proposals outlined earlier would encourage a greater utilization of distinct part facilities by assuring a rate of return commensurate with that experienced in the comparable sections of the institution.

Regarding retroactive denials, let me say briefly that the committee is well aware that this type of abuse of the program needs immediate attention.

GUARANTEED ADMISSIONS

We support the staff view that the law should be amended to provide for "guaranteed" ECF admissions with the specific number of days assured coverage being related to the nature and seriousness of the illness. We suggest, further, that the committee give consideration to including an incentive provision, one that would encourage beneficiaries to utilize the less expensive ECF for rehabilitation and recuperation instead of the hospital. This could be accomplished by allowing patients to trade "guaranteed days" in the hospital for ECF days. The shorter the hospital stay, the longer the patient would be assured coverage in an ECF. Such a proposal would gather added impetus if the law were amended to reduce the number of hospital "free" days from 60 while boosting the number of "free" ECF days up from the present 20 so that benefit periods correspond. This would be reflected in a substantial lowering of hospital benefit claims under the program, as physicians and patients come to accept the validity of the ECF as a fully competent and far more economical facility for recuperative and restorative care, provided UR is substantially strengthened and reactivated.

SKILLED NURSING HOMES AND ICF'S

Intermediate care, as the staff report indicates, was intended to provide a level of care under the medicaid program different from that offered in the skilled nursing home. One of the things not clearly established in the 1967 Social Security Amendments was the degree of nursing care below skilled care which was contemplated. That decision was left to the States.

Some States accepted this new category and structured their regulations according to the needs and requirements of patients. But some States, my own State of Ohio, for example, flaunted both the congressional intent and their own existing regulations. In implementing the ICF program in Ohio, payments for both skilled care and intermediate care were set at almost the same level—$14 and $9 for skilled care, according to patient classification, and $11 and $9 for intermediate care, according to identical classifications. Those facilities in Ohio which could not meet title XIX requirements as skilled nursing homes

were, in fact, reclassified as ICF's. The same patient mix exists in these homes today as existed prior to the ICF program. No professional medical determination was made as to where patients belong. Rather, a financial determination was made as to how much the State was willing to pay for care. Adding insult to injury, just this past week the Ohio Department of Welfare established a new level of payment for "custodial care" in both skilled and intermediate care homes. In this latest instance, a rate of $6 per day is to be paid for custodial care, regardless of facility certification.

The Department's action is indefensible. It deliberately circumvents the intent of the Congress, which is to create programs and provide matching funds for the specific levels of care which program participants require. It should be challenged.

This example points up the importance we attach to the staff recommendation concerning the need for independent medical review and evaluation of a patient's needs. We feel strongly that no State agency which contracts and pays for services should be permitted to make this medical evaluation. Ideally, the States should contract for these services with the medical societies in the local communities. Failing this, and forced to resort to utilization of State agency personnel, it should be required that the agency performing this service have the medical competence needed and be completely divorced from the placement and rate-setting agency.

We urge upon this committee the importance of amending the law to provide a more exacting definition of an ICF, of the level of care that must be provided and what levels of care may not be provided. Equally important is the development of guidelines which will enable clarification and identification of the disabilities which should go into the determination of just what an ICF patient is, or should be.

It seems imperative to us, in order for a well-conceived ICF program to be developed and enlarged, that an additional Federal matching formula relating to the medically needy categories be developed. This would cover persons who are in need of institutional care but for whom States now have only title XIX skilled nursing services available on a matching basis. Such a conclusion obviously flows from the fact that if it is inappropriate for the public assistance recipient to remain in a skilled nursing home if he only requires intermediate care, it is equally inappropriate for the medically needy recipient to remain in a skilled home if his needs could be met in an ICF.

It is our belief that the ICF program, fully developed and utilized, offers significant potential for cost savings while assuring adequacy of care appropriate to the needs of the individual patients.

One final comment. Over the past few months, we have had extreme difficulty in obtaining understandable regulations as to allowable methods of payment under title XIX State plans. We won't go into the history of the problem, but we would like to submit for the record a payment method which a number of State associations representing nursing homes have developed. A modification of the plan, which for the lack of a better title we refer to as the "flexible payment plan," has already been worked out by the State of Wisconsin and the Wisconsin Nursing Home Association and has been transmitted to the Department of HEW for approval.

The plan is a unit-of-service formula. It combines a basic rate with unit rates for additional units of service, all related to the diverse

services available and utilized. According to the degree and quality of service, the resultant rate reflects a solid basis for budget preparation, provides incentive for nursing homes to improve and expand their services, provides positive control of rising costs, is prospectively related to costs, eliminates the need for costly and burdensome audits, and is flexible enough for modification to the needs of State nursing home programs. We would not suggest that any State be required to use a single method, but offer this as one alternative that should be made available. We understand that HEW advised Wisconsin nursing home and State officials they consider the plan "unique and interesting" but would be unable to authorize its implementation under the present limitations imposed by the title XIX reasonable cost limitation. Hopefully, the changes this committee will sponsor this year will allow this kind of payment plan to be available to those wishing to utilize it.

We thank the committee for its patient and understanding reception of our views and assure you, Mr. Chairman, that we will give freely of our time and energies to assist the committee and its staff in any manner you deem appropriate. We, like you, are concerned that the needs of the patients be properly met. And we, like you, are concerned that expenditures to adequately meet these needs reflect a dollar's value for every dollar spent.

Now, Mr. Chairman, may I introduce Mr. Powell.

Mr. Powell. Mr. Chairman and members of the committee, I, of course, concur in the statements made by Mr. Stewart and Mr. Wheeler and particularly would like to reemphasize the importance of developing a new method for reimbursement of providers under the medicare program.

There is much merit in Mr. Wheeler's proposal concerning the very real distinctions between the three types of ECF's—the major providers, the substantial providers, and the casual providers. I believe that recognition of this fact in a new formula will do much to encourage greater participation in the program by the long-established, well-administered nursing homes which heretofore have declined to seek certification under the program.

Concurrent with the development of a new formula, however, is the need for a major overhaul in utilization review procedures. Fortunately, we in Louisiana have not experienced major problems with utilization review, principally because we have developed an excellent medical review procedure which precedes the UR. But the word "tokenism" best describes the manner in which UR has been carried out in hospitals in most States. This is an indisputable fact, well documented by the inordinate number of retroactive denials for care provided by ECF's immediately following periods of hospitalization.

The patient and the ECF have become helpless pawns in the "guessing game" created by failure of UR to work properly. As originally intended, UR was to be the mechanism by which medicare beneficiaries were to be moved from the most expensive institutional setting, the hospital, to the less expensive setting, the extended care facility. The flood of retroactive denials, primarily based on the grounds that the patient required only "custodial care" upon his arrival at an ECF, or shortly thereafter, is ample evidence that hospital stays have been too long, creating an excessive drain on tax dollars. We heartily concur with the staff recommendations for substantial tightening of UR procedures.

In this regard, I suggest that the committee may well wish to consider broadening coverage under title XVIII to provide the physician with institutional alternatives that more nearly meet the physical care of specific patients. At the moment, the only covered institutional care for medicare patients beyond the hospital is the ECF. Not all beneficiaries, however, require the sophisticated care and intensive nursing services provided by an ECF. As an example, a hip fracture patient, following corrective surgery and a period of hospitalization, may not require the intensive services provided in an ECF. A more appropriate level of care could be provided in a skilled nursing home, or even an ICF. At the present time, the evidence indicates that such patients are being kept in the hospital setting for the recuperative period when they could and should have been moved into ECF's. In some instances, extensive and expensive physical therapy services have been prescribed, primarily to assure that benefits will be forthcoming under the program.

If the attending physician had a choice, and UR were working properly, I think that in many such cases the patient would be moved to a skilled home of an ICF, with substantial savings to the program. I urge the committee to give this possibility some thought. But I caution that any such change, without a substantial revision in the method of payment to providers, will undoubtedly meet with continued apathy on the part of the many good facilities which have either stayed out of the program or have withdrawn from the program because of frustration and financial loss.

ADMINISTRATOR LICENSURE

I would like next to direct the committee's attention to a matter concerning the administrator licensing law, a matter which I believe was truly the result of legislative oversight. The present law requires that a professional license may be issued to an applicant who has served as an administrator in a licensed nursing home or an I.C.F. for at least a full calendar year preceding implementation of the law. In all of the discussion concerning this requirement, it was my understanding, shared by many others, that what was intended was evidence that the person had performed such duties for a period of twelve months prior to the law becoming operative. However, the law does not become operative until July 1, 1970. The wording, "calendar year" thus creates the requirement that the applicant must have served at least 18 months in such a post, rather than the intended 12 months.

In behalf of the four State associations we are representing here today, and many other concerned leaders in the industry, I respectfully suggest that this committee seek enactment of an amendment to the licensure law which would substitute a 12-month period preceding the July 1, 1970 date for the current language which refers to the "calendar year" preceding that date.

MEDICAID COMPLIANCE—NURSING SERVICES AND FIRE AND SAFETY STANDARDS

Finally, may I discuss briefly our concern with the need to speed up the mechanisms by which facilities can achieve full compliance with the various standards set for skilled nursing home participation in the medicaid program. Those of us who struggle daily to maintain appropriate staffing levels in an industry sorely taxed by shortages of professional and subprofessional personnel face July 1, 1970 with mounting trepidation. That is the date, you will recall, by which the Department of Health, Education, and Welfare has decreed that waivered LPN's may no longer serve as charge nurses in skilled nursing homes.

HEW seems determined to follow through with this prohibition, in spite of the fact that it has utterly failed to provide the training programs which would have enabled those presently waivered to meet the requirement as charge nurses. We express our concern and alarm that large numbers of fully competent LPN's who have not been given the opportunity to achieve this status because HEW has failed in its mission, will be lost to the program. There is little likelihood that fully qualified replacements can be found. The end result inevitably will be the withdrawal of substantial numbers of facilities from the program or, as has happened in a number of States, the wholesale reclassification of homes and their patients to a lower level of participation. The latter course poses the obvious problem of such homes further reducing staffing patterns to the lower category with possibly adverse effects on the patients, who in the first instance were placed in skilled nursing homes because of their needs.

We believe that the seriousness of this problem dictates forceful action by this committee requiring HEW to defer temporarily the effective date of this prohibition and to proceed forthwith to comply with the mandate first issued by the Senate Finance Committee in 1967. That was, as you will recall, a directive that HEW provide the necessary proficiency training and testing procedures to enable waivered LPN's to attain full status as charge nurses.

In the matter of achieving full compliance with the fire and safety standards set for participating homes under medicaid, we feel that the escape mechanism of "substantial compliance" has been overused. Exposure of patients to unnecessary hazards is indefensible, and we take the view that participating facilities should be put on notice now that they must either make the capital expenditures necessary to conform to the standards or withdraw from the program. At the same time, States which have shown a marked unwillingness to enforce the fire and safety standards in order to avoid higher patient care costs, must be put to the test. It should be made abundantly clear that continued State participation in the substantial Federal sharing of costs may be jeopardized by failure to move quickly and effectively toward full compliance with fire and safety standards.

We have offered our thoughts and recommendations in a spirit of cooperation and helpfulness. We are grateful for the patience and interest exhibited by the committee and offer our continued assistance and support in your work in the weeks and months ahead.

Thank you, sir.

Senator ANDERSON. Senator Ribicoff?

Senator RIBICOFF. Mr. Stewart, I was a little puzzled. You talked right at the beginning of your testimony about wide-spread payoffs and kickbacks. Payoffs and kickbacks from whom to whom and between whom?

Mr. STEWART. Senator, the payoffs and kickbacks I am talking about are the well-publicized things that have been dug out by GAO and many Government agencies. These are established and documented, things that we feel have caused the problems. Payoffs and kickbacks between the nursing home administrator and/or owner in the purchasing of service and vendors of service. We even have in some instances—I do not have all these examples here before me, but I am sure you are familiar with some of them, one such example is the nursing home administrator who goes into supermarkets and picks up other people's grocery slips in order to substantiate higher food costs more common are the incidences of ancillary medical suppliers who return a portion of their institution charges to the NIH, owner or even "rent" closets for patronage. The druggist who charges for brand drugs and supplies generic, and so on.

We are just completely opposed to any of these sorts of things. We feel that the mechanism is available to this body and to the Congress to stop it and we just feel that Government has been too lenient with people when this sort of thing is proven or alleged.

My personal opinion is: put a padlock on the door when it happens. If a man is guilty of a fraud, put him in jail, to be perfectly simple about it.

Senator RIBICOFF. Do you find that this is a widespread practice in the medicare program in the various institutions with which you are familiar?

Mr. STEWART. No, sir; I do not think it is a widespread practice as we consider all of the facilities. I do think it is more widespread than the industry can in all fairness admit. I think that in even one or two instances, it is too widespread, because this hurts the industry; it hurts the Congress; it destroys the credibility of the program when this happens. Even one place, in our opinion, is too widespread.

Senator RIBICOFF. Now, you gentlemen mentioned the shortage of personnel to enable you to properly staff your faciilites. This comjobs for people on welfare.

mittee will soon be faced with a new welfare bill. Part of it entailed

Do you think there could be set up in any large community or throughout the State training programs for subprofessionals out of welfare recipients, or the underemployed, who would work in nursing homes, extended care facilities, and hospitals?

Mr. STEWART. Sir, we are utilizing every agency in the city of Little Rock, because this is our largest urban area, where unemployment is most rampant in this very underprivileged, sometimes "unemployable" term that has been applied. We are taking these people from the training. The programs are overlapping in that we send them, or the administrator of the training program sends them to the VA hospital or to the State hospital or to the local hospital, gives them some aide training, knowing in advance that we will take them once they get them trained. We are using these people and we have

found that it helps a great deal. We do not have an aide shortage any longer since they have gone into this. This does not go far enough with the LPN and APN's.

Senator RIBICOFF. I understand, but I am talking about the large mass of subprofessionals. I do not expect you to take a person on welfare and make him a trained nurse; I understand that, but there is subprofessional and paramedical help. Some of them are very intelligent people who need training, who have no skills. It should not be difficult to train people for wellpaying jobs in the facilities you gentlemen operate.

Mr. STEWART. Yes, sir.

Senator RIBICOFF. In your respective States, do you have any training programs for subprofessional employees in hospitals or nursing homes or extended care facilities? Are there in your State such programs?

Mr. WHEELER. There are in the State of Ohio. They are rather small training programs, I think, most usually set up in individual communities. But, certainly any further effort under your future bill that you are suggesting would be very helpful, I believe, and we certainly embrace them.

Senator RIBICOFF. Are these local programs? Are they being done by the Labor Department or HEW in Little Rock?

Mr. STEWART. It is Federal grant money that is doing it; yes.

Senator RIBICOFF. But there are programs and you are finding people who come out of these programs who are good workers?

Mr. STEWART. Yes, sir; we are asking for them in advance. The percentage of bad employees that we get—of course, 100 percent of them do not turn out well, but the biggest part of them, we believe, 90 to 95 percent of these people stay and work up and make more money.

We were a little worried about it to start with, when they said, frankly, these are unemployables that we are training. We have found they were not unemployable; they were just not trained to do anything and they made us some good workers.

Senator RIBICOFF. When they start off on the training program, how much do you pay them?

Mr. STEWART. We pay at least the minimum wage.

Senator RIBICOFF. And as they work themselves up and get more training, what do their salaries become?

Mr. STEWART. Sir, I would not hazard a figure, but with the minimum wage at $1.45, it would easily go up in 2 or 3 months to $2 an hour.

Senator RIBICOFF. In just a few months?

Mr. STEWART. If they deserved it in 2 or 3 months, or they could be there a year later, in all honesty, still drawing only $1.45 an hour, depending on their willingness, their interest, the interest in the patient, rather than the timeclock.

Senator RIBICOFF. What are you finding of these people working in your facilities? Are they working 40-hour weeks or working overtime, too?

Mr. STEWART. Mostly the 40-hour week. They work overtime when we need them—not the 40-hour week, the 48-hour week, which is allowed in nursing homes.

Senator RIBICOFF. So, they work a 48-hour week and they start off at a minimum of $1.45.

Mr. STEWART. Yes, sir.

Senator RIBICOFF. And you could use as many trained people as you could find?

Mr. STEWART. Yes, sir; this is substantially correct.

Senator RIBICOFF. Based upon the experience and reports of your members, do you find that hospitals are keeping medicare patients longer than required for sending them on to extended care facilities and nursing homes?

Mr. STEWART. Absolutely. I cannot speak for the other States, but in our State, the medicare program, title XVIII, has no meaning of any consequence in nursing homes in Arkansas, simply because we cannot get them certified; the doctor cannot get them certified into an ECF. They can get about as many days as the doctor wants them to have if they stay in the hospital, but once they move that patient over to the ECF, he is either denied then or retroactively.

So, after this doctor goes through this two or three times with some very angry families and some nursing homes who are upset, and of course, everybody says it is the dirty old nursing home that caused the trouble, then the doctor says, "Why bother? I'll keep them in the hospital; I'm making rounds every day."

You cannot blame the doctor. We go to Blue Cross, our fiscal intermediary. They say, "We cannot help it, our hands are tied by Social Security." We talk to Social Security and we have done the whole round robin.

Senator RIBICOFF. In other words, it is a continuous runaround?

Mr. STEWART. Yes, sir. The patient stays in the hospital at $60 to $100 a day.

Senator RIBICOFF. What is the average cost of a hospital stay in Little Rock, and what is the average cost of a day in one of your facilities?

Mr. STEWART. About $64 a day in a hospital, and not over $13 a day in ECF, and we have many ECF beds available, which meet every regulation. We do not have one ECF which is of any waivered or "substantial" compliance. We do not allow waivered ECF's in our State.

Senator RIBICOFF. So there is a differential of about $50 a day?

Mr. STEWART. Yes.

Senator RIBICOFF. That is all, Mr. Chairman.

Senator ANDERSON. Senator Williams?

Senator WILLIAMS. I have no questions.

Senator ANDERSON. If you people will stay here for a while, we have something we will have to attend to on the floor and the staff will stay on to ask you some questions, if you do not mind.

The next witness is the Associated Physicians of the Cook County Hospital, Dr. Robert J. Baker.

STATEMENT OF DR. ROBERT J. BAKER, PRESIDENT, ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL, CHICAGO, ILL.; ACCOMPANIED BY DR. ROBERT BOUER, PRESIDENT, MEDICAL AND DENTAL STAFF, COOK COUNTY HOSPITAL; DR. VINCENT J. COLLINS, SECRETARY, MEDICAL AND DENTAL STAFF, COOK COUNTY HOSPITAL, AND TREASURER OF THE ASSOCIATION AND DIRECTOR OF THE DIVISION OF ANESTHESIOLOGY OF COOK COUNTY HOSPITAL; AND WILLIAM B. SALE, ADMINISTRATOR, ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL

Dr. BAKER. Mr. Chairman, I am Dr. Robert Baker, the president of the Associated Physicians of the Cook County Hospital.

On my left is Dr. Vincent J. Collins, secretary of the medical and dental staff of the Cook County Hospital, treasurer of the association, and director of the division of anesthesiology of the hospital.

To my immediate right is Mr. William Sale, who is the administrator of the association, and on my far right is Dr. Robert Bouer, who is president of the medical and dental staff of the Cook County Hospital.

Mr. Chairman and members of the Subcommittee on Medicare and Medicaid, of the U.S. Senate Committee on Finance:

My associates and I are pleased to have this opportunity to clarify the organization and operations of the Associated Physicians of the Cook County Hospital, particularly with respect to hearings held by the Full Committee on Finance on July 2, 1969.

I should like to preface my very few comments with a statement in which I think it is fair to assert that the whole medical profession owes a very deep debt of gratitude to the Congress, and especially to you, Senator Anderson and Senator Williams, for your intensive efforts to set up and make operational an extremely broad and complex program such as the medicare and medicaid programs. However, I think that certain misunderstandings have arisen in some areas, and we would like to clarify our position.

In his letter of July 22, 1969, to Mr. Jay Constantine, Mr. William Sale, administrator of the association, made the following comments with respect to the July 2 hearings:

> I have reviewed carefully the transcript of the hearings of the July 2d meeting of the committee and am very much concerned respecting the apparent misunderstandings on the part of both Senators and witnesses, concerning the operations of the Associated Physicians of the Cook County Hospital. It is my understanding that the principal sources of information before the committee, on which the July 2d hearings were based, were (1) the series of articles by Miss Effie Alley, appearing in Chicago's "Today" on March 20, 21, and 22, 1969; (2) a written statement by Dr. Samuel Hoffman, director of the Division of Laboratories, Cook County Hospital who, although he was a founder of the association, and a member of the board of directors and the finance committee of the asociation until his resignation on February 1969, cannot and does not speak for the association, the medical staff, or the hospital; and (3) the preliminary draft report of the General Accounting Office which had been submitted to the principal individuals concerned, including myself, for comment and correction prior to publication of the definitive report of the GAO.

On the same date Mr. Sale transmitted to Mr. Constantine for the information of the committee a copy of his letter of July 16 to the

General Accounting Office providing our comments and suggested correction and revision of the General Accounting Office Draft Report to the Committee on Finance, which had been discussed at the July 2 hearings. The revised GAO report, submitted to the Committee on Finance on September 3, 1969, incorporated many of the corrections and suggestions presented by the association. On February 11, 1970, the GAO transmitted to the committee an additional report on the status of the association.

With his letter of March 24 to Mr. Constantine, Mr. Sale submitted, for the information of the committee, copies of his letters to various members of the medical staff of the hospital commenting on their letters to Mr. Walter R. Livingston of the Illinois Medical Service, which had been printed in the Congresional Record of January 26, 1970.

I refer to this documentation to point out that members of this subcommittee have received considerably more additional information concerning the association than was available to them at the time of the hearings of last July. As a consequence, we would hope that much of the misunderstanding respecting the association which seemed to exist at the time of the July hearings has since been clarified.

As I believe the members of the subcommittee are aware, after many months of discussions with the carrier, Illinois Medical Service, and with regional and national representatives of the Social Security Administration, the association reached an agreement with the Social Security Administration providing for repayment of whatever overpayments had been made to the association on past medicare claims and for the prompt resumption of the processing by the carrier of pending and current medicare claims by the association.

I am appending hereto, for the completion of the record, copies of resolutions adopted by the board of directors of the association on February 23, 1970, and a letter dated March 13, 1970, from Mr. Fred Wolf, Chicago regional representative of the Bureau of Health Insurance. In his letter Mr. Wolf states that "On the basis of these resolutions, I believe this matter can be resolved in a way that is fair to the association and the U.S. Government."

My colleagues and I wish to reiterate our firm belief that all medicare claims submitted by the association were submitted in complete good faith on the understanding that billing procedures were in full compliance with the requirements of the printed Federal regulations establishing provisions for reimbursement for part B payments for services of supervising physicians in a teaching setting, Social Security Administration guidelines in effect at the time that claims were submitted, and agreements between the association and the Illinois Medical Service concerning billing procedures. While we have questioned the propriety of the imposition by the Social Security Administration of retroactive guidelines in connection with readjudication of claims submitted by the association under the terms of earlier regulations, the association has agreed to payment of the Social Security Administration's overpayment claims in the interest of resumption of collection of outstanding and current medicare claims and, of even greater import, in order to resolve a problem which has caused so much unwarranted distress to the members of the professional staff of Cook County Hospital.

Mr. Sale will be pleased to furnish to the staff of the subcommittee additional documentation providing greater detail with respect to our negotiations with the carrier and the Social Security Administration. My colleagues and I are available now to respond to any questions on the part of the members of the subcommittee.

(Material referred to previously follows. Hearing continues on page 475.)

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL,
Chicago, Ill., February 24, 1970.

Mr. FRED WOLF,
Regional Representative, Bureau of Health Insurance, Social Security Administration, Chicago, Ill.

DEAR MR. WOLF: By direction of the Board of Directors of the Associated Physicians of the Cook County Hospital, I am sending you herewith the text of resolutions adopted by the Board of Directors of the Association at its twentieth meeting on February 23, 1970.

Upon receipt from you of a letter of acceptance of the sense of these resolutions with respect to provision for settlement of the United States Government's claim referred to in these resolutions, I shall deliver to you the Association's check in the amount of $300,000 in accordance with resolution number 3.

I shall also be prepared to meet with representatives of the Bureau of Health Insurance, Social Security Administration, and the carrier, Illinois Medical Service, to arrange for the prompt resumption of payments of pending and current claims as provided in resolution number 4.

I wish to express to you and your associates in the Department of Health, Education and Welfare my personal appreciation for your understanding and cooperation in helping to arrive at an amicable resolution of a most complex and difficult problem. We look forward to working with you and the carrier toward more positive achievements which will enable the Association to resume its programs in support of improved health care in Cook County Hospital and in our larger community.

With best regards,

Sincerely,

WILLIAM B. SALE, *Administrator.*

Enclosure.

RESOLUTIONS ADOPTED BY THE BOARD OF DIRECTORS OF THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL AT ITS 20TH MEETING ON FEBRUARY 23, 1970

Whereas the Associated Physicians of the Cook County Hospital (hereinafter referred to as the Association), by the following resolutions, desires to reach an accommodation with the Federal Government which will settle the question of overpayments of past Medicare claims, and provide for the prompt resumption of payment of pending and current claims in order to continue the Association's program of assistance for the improvement of health care at Cook County Hospital, it is deemed appropriate to record herein certain facts concerning the establishment, purposes and operation of the Association, and the development of the circumstances which have led to suspension of payment of Medicare claims to the Association since last April.

Whereas the Association was established pursuant to resolutions of the Executive Staff of the Medical Staff of Cook County Hospital, on the basis of recommendations of an ad hoc committee under the chairmanship of Dr. Fred Shapiro, Articles of Incorporation were secured by Dr. Edmund F. Foley, President of the Staff, Dr. Karl A. Meyer, Medical Superintendent of the Hospital, and Dr. Samuel J. Hoffman, Director of Laboratories and Director of the Hektoen Institute for Research of the Cook County Hospital; the establishment and organization of the Association, the appointment of its Administrator, and the "Principles and Procedures" for billing for Medicare claims were approved by the Executive Staff; the then governing body of the Hospital, the Board of Commissioners of Cook County, were kept fully informed of these developments.

Whereas the Association has in all good faith attempted to interpret and comply with the intent of the Federal Regulations as administered by the carrier, Illinois Medical Service (hereinafter referred to as IMS), and the Social Security Administration (hereinafter referred to as SSA); and

Whereas the Association submitted claims for reimbursement for services rendered to Medicare-insured patients by and under the supervision and direction of its attending physician members at Cook County Hospital, and has used its funds, in accordance with its Articles of Incorporation and By-Laws, for the improvement of patient care at Cook County Hospital and for the advancement of education in the health sciences among the dedicated but disadvantaged young men and women of the community; and

Whereas the Directors and Administrator of the Association have worked in close collaboration with the carrier, IMS, and the Chicago Regional Office of the SSA in an attempt to ensure that the program of the Association was in full compliance with Federal Regulations; and

Whereas, at no time, from the inception of the Association's negotiations to establish the program in early 1968, through the most recent period of discussions of the Association's obligations under the new interpretation of Federal Regulations by SSA, has there been any question whatsoever on the part of either the carrier or the Federal departments concerned respecting the integrity and good faith of the Directors and members, and the Administration of the Association; and

Whereas despite the difficult experience of subjection to misinformed and in some cases malicious public statements concerning the operations and intent of the Association, the Association will continue to pursue its efforts to bring better health care to the people of our community, in which intention the Association has the full support and cooperation of the Administrator of the Cook County Hospital and of the new Governing Commission for County Medical Institutions; and

Whereas the Association has been advised by SSA, on the basis of readjudication of the 75 claims submitted by the Association for payment under the terms of Title XVIII of the Health Insurance for the Aged Act which were reviewed by the General Accounting Office (hereinafter referred to as GAO), that the Association has received overpayment of Medicare claims amounting to $1,109,000; and

Whereas in order to resume the development of its programs, the Association, while reserving its own contrary views, and specific rights under the law, will not contest the demands of the Federal authorities that overpayments amounting to no more than $1,109,000 must be refunded to the United States Government; and

Whereas SSA has further instructed the Medicare carrier not to process pending or current Medicare claims from the Association until agreement has been reached on the method of repayment of said overpayment; and

Whereas the Association, being desirous of reaching agreement with SSA on the method and manner in which this claim may be repaid to the Federal Government, which repayment should be on no less favorable terms to the Association than to similar organizations throughout the nation likewise situated and against whom similar claims have been made by SSA; Now, therefore, be it

Resolved, That the amount determined by SSA to be the amount overpaid to the Association by the Medicare carrier under the terms of Title XVIII, regulations and agreements implementing such Act, shall be repaid by the Association to the Federal Government as herein authorized; the determination of such amount by SSA to be subject to verification by the Association on the basis of national policy for adjudication of overpayments and the manner of its application; and that such amount shall be in full payment and satisfaction of all liability of the Association, its agents, employees, officers, directors and members, arising by reason of any and all alleged overpayments heretofore made to the Association; and be it further

Resolved, That the Administrator of the Association will transmit a copy of these resolutions to SSA with a request that SSA accept the sense of these resolutions as the basis for repayment as herein provided of the full amount claimed by it as stated herein, and prompt resumption of the processing of pending and current claims; and be it further

Resolved, That upon receipt of the above-referenced letter of acceptance from SSA, the Association, in token of its willingness to resolve this problem within a reasonable time, will pay the sum of $300,000.00, as specified by the SSA, to the Government of the United States; and be it further

Resolved, That the Administrator of the Association is hereby authorized and directed, with the advice and counsel of the Association's legal representative to negotiate arrangements (subject to approval of the Association) for the repayment to the Government of the United States of the remaining balance

of said overpayment through the withholding by the Medicare carrier for purposes of offset against such remaining balance a percentage of the net amounts found to be due on Medicare claims which the Association has submitted to the said carrier and which may be submitted in the future. The determination of the percentage or amount of payments to be withheld shall be established so as to insure full payment of the entire balance due in generally equal installments over a period of not more than 36 months from the date of adoption of these resolutions.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Chicago, Ill., March 13, 1970.

WILLIAM B. SALE,
Administrator, The Associated Physicians of the Cook County Hospital,
Chicago, Ill.

DEAR MR. SALE: This is in reference to the Resolutions passed by the Board of Directors of the Associated Physicians of Cook County Hospital on February 23, 1970, concerning the overpayment of the Association under Title XVIII of the Social Security Act. On the basis of these Resolutions, I believe this matter can be resolved in a way that is fair to the Association and the United States Government.

At the outset, however, I must make it clear that the Social Security Administration's responsibility in this matter is limited to the determination of the overpayment and to the recoupment of funds to satisfy the Association's indebtedness, including the manner in which such recoupment is made. We have noted the statements in the Resolutions bearing upon the good faith with which the claims for reimbursements were made and the integrity of the Directors and Members of the Association; however, you will appreciate that these are matters which were not germane to the decisions of the Social Security Administration in exercising its responsibility in this case.

In response to your request I shall attempt to set forth my understanding as to how the overpayment arose. The bills for Medicare payments that were filed by the Association for services performed by physicians in Cook County Hospital were submitted under the provisions of Intermediary Letter No. 221. As stated in that document, the test as to whether a service rendered by a physician in a teaching setting is compensable, depends upon whether the physician rendered a personal and identifiable service to the patients or rendered personal and identifiable direction to the resident or intern at the time when the service was being rendered by the resident or intern. The billings submitted by the Association apparently did not represent, in all instances, charges for services of physicians in the Cook County Hospital performed in the manner prescribed in Intermediary Letter No. 221.

To determine the amount of the overpayment we, in conjunction with the General Accounting Office, examined the medical charts and records in 75 cases. The documentation in these charts and records showed generally that a patient entering Cook County Hospital was assigned to an attending physician. However, in only some of the cases was there documentation that this physician or any other physician (not a resident or intern) rendered a personal and identifiable service to the patient. Similarly, there was a lack of documentation to show that when the service was provided by a resident or intern there was a physician who provided personal and identifiable direction to the resident or intern as required by the regulations of the Social Security Administration and as contemplated by Intermediary Letter No. 221. Because the documentation did not support the claims with respect to a large portion of the billings, it was necessary to disallow a substantial number of claims with the result that an overpayment arose.

Insofar as the Resolutions of February 23, 1970, are concerned, I have been authorized to advise the Board of Directors of APCCH as follows:

1. The Social Security Administration has and hereby does determine the overpayment to the Associated Physicians of Cook County Hospital to be $1,109,000.

2. The provision in the Resolutions for an immediate payment by the Association of $300,000 in partial liquidation of its indebtedness is acceptable to the Social Security Administration.

3. Upon receipt of the $300,000, the Social Security Administration is prepared to do the following:

a. Instruct the carrier, Illinois Medical Service, to proceed to an adjudication of APCCH claims now pending with it, and after a medical audit of a representative sample of these claims, to be determined by the Social Security Administration, credit to the account of the Association the amount determined payable on the basis of those pending claims. This medical audit would be made under the same principles applied in adjudicating the claims in the General Accounting Office sample.

b. Take proper adjudicative action on claims now in your possession which, I understand, you intend to file with the carrier, and credit the Association's account in the same manner as in a. above.

c. Instruct the carrier to meet with you as quickly as possible to explain the policy behind Intermediary Letter No. 372 so that processing of current claims can start as soon as possible.

4. As soon as we have information on the amounts determined under either paragraphs a. or b. of 3. above, or on the amount that we can expect to be payable under paragraph c. of 3. above, we shall make provision, after appropriate consultation with the Association, for payment of a percentage of the amounts so determined in any or all of the three categories of claims. This percentage will depend upon the extent to which the Social Security Administration has assurance that the amounts withheld will result in liquidation of the indebtedness over a period not to exceed 36 months. However, the overpayment schedule will be accelerated if the volume of claims submitted generates payments which are substantially in excess of what the Association needs to meet its authorized expenses.

5. The Resolutions state that any repayment "should be on no less favorable terms to APCCH than to similar organizations throughout the nation likewise situated, and against whom similar claims have been made by the SSA." As we have indicated to you orally in our discussion, the Medicare law is a national program and any policies we adopt under the law are applied nationally. The basic standards and criteria used to determine the overpayment have been applied in determining overpayments in situations throughout the nation comparable to the one presented to us by the claims filed by the Association. All determinations concerning present and future claims for services of physicians in a teaching setting will be made pursuant to the provisions of the Act and regulations applicable to such claims nationwide. The determination of the overpayment contained in paragraph numbered 1. above and the method and manner of reimbursement of such overpayment set forth in paragraphs numbered 2, 3 and 4 above, are made under the authority of the provisions of Title XVIII of the Social Security Act, as amended, in regard to overpayments and their recovery, and the exect of such reimbursement shall be as set forth in such statute. The provisions of this letter do not have any reference to any other authority of the Secretary and cannot extend to any Federal agency operating under any other provision of law.

6. With respect to the claims filed by the Association of which $1,600,000 was paid to the Association prior to the suspension of payments on April 18, 1969, the Social Security Administration has determined that there has been an overpayment of $1,109,000. Upon repayment by the Association of the amount of the overpayment in the manner prescribed in this letter, no demands for any additional payment will be made by the Social Security Administration or the carrier, Illinois Medical Service, against the Association, its agents, employees, officers, or members, with respect to the payments made on the claims specified in the preceding sentence.

I hope this letter will be a basis for taking final action to conclude this matter.

Sincerely yours,

FRED B. WOLF,
Regional Representative, Health Insurance.

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL,
Chicago, Ill., March 13, 1970.

Mr. FRED WOLF,
Regional Representative, Bureau of Health Insurance,
Social Security Administration,
Chicago, Ill.

DEAR MR. WOLF: I have received your letter of March 13 acceping the sense of the resolutions adopted by the Board of Directors at its 20th meeting on February 23 respecting provisions for repayment of overpayments on Medicare claims

paid to the Association by Illinois Medical Service, and prompt resumption of processing by Illinois Medical Service of pending and current Medicare claims of the Association.

Pursuant to resolution No. 3 of the referred to resolutions, I am transmitting herewith the Association's check to the order of Illinois Medical Service in the amount of $300,000.00 in partial liquidation of the Association's indebtedness arising as a result of the referred to overpayment.

We look forward to working with you and Illinois Medical Service to effect the prompt resumption of processing of the Association's Medicare claims as provided in paragraphs 3, 4, 5 and 6 of the letter of March 13.

Sincerely,

WILLIAM B. SALE, *Administrator.*

Senator ANDERSON. Do you have any additional statement to make?

Dr. BAKER. No, sir.

Senator WILLIAMS. Mr. Chairman.

Dr. Baker, it is my understanding that the hospital and the Government have reached some sort of agreement with respect to the overpayments of about a million-some dollars; is that correct?

Dr. BAKER. That is correct.

Senator WILLIAMS. And that there are certain aspects of the situation that are now in the courts. Is that not true?

Dr. BAKER. That are being what, sir?

Senator WILLIAMS. I mean, certain aspects of this situation are being considered in the courts. I think in the light of that situation I would refrain from any questioning at this point.

As one member of the committee, I would refrain from questioning under the circumstances under which we are operating.

Dr. BAKER. To my knowledge, Senator Williams, there is nothing in court that affects the association. But it may be that we are not privileged to that information.

Senator WILLIAMS. Perhaps not the association directly, but some members of the association; is that not true?

Dr. BAKER. Yes; I think that is true, sir.

Senator WILLIAMS. And they are in court, and some of the witnesses are here. Under the circumstances I want to refrain from asking any question that may be misunderstood in relation to the court cases.

Senator ANDERSON. Are there any questions by the Senator from Connecticut?

Senator RIBICOFF. No questions, Mr. Chairman.

Senator ANDERSON. We shall finish one more statement here this morning, and if you gentlemen will stay for a while, the staff will ask some questions of you.

Thank you very much for appearing.

Dr. BAKER. Thank you, Mr. Chairman.

Senator ANDERSON. Dr. Hall?

(No response.)

Senator ANDERSON. Dr. Hall is not here.

Mr. Stewart, the staff has some questions to ask of you and your group.

The STAFF. Are you gentlemen concerned in any way about the growth of health care chains and conglomerates?

STATEMENT OF CHARLES A. STEWART—Resumed

Mr. Stewart. Yes, sir; very much so. We do not wish to label all health care chains and conglomerates as bad for the public or bad for the nursing home industry. Or, most important, bad for the patient. We are concerned with those isolated cases, and sometimes a little more than isolated, in which chains and conglomerates have, we feel, hurt the nursing home industry in several different ways in projecting an unfair image to the public in order to sell stock, in utilizing certain practices within that chain nursng home in order to make money for their board of directors, in doing many things that we do not feel are consistent with the overall objective of this body, the Congress, and with the vast maojrity of people who are in the nursing home profession to give good care to the patients.

It is in that concept that we oppose those chains and conglomerates who are there for only one reason. We do not avoid the term "profit." We think that industry of any kind that uses its own money is entitled to a reasonable profit, but when the patient is manipulated and the public is manipulated for an excessive profit, we oppose it 1,000 percent.

The Staff. You spoke of not accepting institutions in substantial compliance for medicare; that is, substandard facilities?

Mr. Stewart. Yes, sir.

The Staff. Do you recommend that participation in the program be restricted essentially to only facilities which are in full compliance?

Mr. Stewart. With very little qualifications, if it were humanly possible, I would like to recommend 24-hour compliance be required. However, I feel this is not exactly possible, because after 2 or 3 years of allowing facilities to be certified that are not in substantial compliance—and I would point out that we went along with this—yet we are not the regulation-making body. I think it would be unfair to say to all of these people who have been allowed to go along for a period of 2 or 3 years, to say overnight you have to do it.

But, I do not back away from my statement. I think as quickly as is possible without imposing a burden, an overwhelming burden on that facility, he must enter into compliance if he is in substantial or fair compliance with it. If he is completely in noncompliance, I do not think he ought to be allowed to operate another 5 minutes.

Staff. How do you gentlemen feel bout reimbursement of substandard facilities—that is, facilities which are permitted to participate in the program with deficiencies. Should they be reimbursed at the full rate basis?

Mr. Stewart. I feel they should not. In the first place if they cannot come up to the standards, I do not think we should later be talking about any reimbursement to them at all. But, if we have to make certain concessions because of this delay, then there could be adjustments made in their reimbursement while they are making these changes. And I agree, there could be a differential here.

Staff. You gentlemen recommended in your statement that medicare's institutional benefit be modified so as also to permit transfer from hospitals to skilled nursing homes and intermediate care facilities as well as extended care facilities. Would you consider a limited benefit there? That is, how many days of care did you have in mind in a skilled nursing home or in an intermediate care facility?

Mr. Stewart. Well, I feel like this is probably one of the most knotty things to unravel. I personally oppose the hatchet approach of saying X number of days, because there is no way we can anticipate what that patient's condition is going to be at the end of that time. I think the guaranteed days—we have been over this—that this can go according to diagnosis as far as hospital days or ECF days.

Now, if that patient does not require extended care facilities benefits, or even skilled nursing care benefits, there is really no way under the sun to determine in advance whether he will sufficiently recover to move—if you were taking him down the two steps to the ICF, he may be there the rest of his life.

The thing that we cannot say is that if we are going to set, and this has been said, as we understand it—it is in the Federal Register—that the States will place patients in facilities that will furnish the service that is required—now, if you are going to say this, how can you say, "but only for a certain number of days?"

Because then, when your days run out, what happens then? So, we are opposed to the concept of saying a certain number of days, mind you, on your thought of skipping the higher priced facilities and moving the patient to that level where he can be accommodated for a lengthy stay less expensive program.

In the skilled care facilities, we are opposed to a limitation of days there, because we felt that skilled, I think the American public thought that title XIX was to take up where title XVIII left off in certain cases and to rather improve the Kerr-Mills approach rather than to destroy that approach.

It is awfully hard to approve in any way a limited number of days where there is no way to expect what that patient's condition will be. I think it has been overemphasized by many people in Government that if we did a better job in physical therapy and mental therpay we could get these people out. Try mental and physical therapy on an 82-year-old patient where there is no way in the world to make him or her better. We can just make them comfortable and give them service. So, we cannot take a number of days.

The month is not really important. The staff is not important when you come to this. We do all we can. They do not come back uphill and go back home and play volleyball. They just cannot be made better. This is why we opposed a limited number of days approach. For the purpose of an extension of medicare coverage, however, and for fulfilling its original intent, at least 30 to 60 days should be considered until utilization review can be straightened out in all participating institutions.

Staff. Do your members understand that medicare is a limited, acute care program, and not for the chronically ill?

Mr. Stewart. Yes; we do not oppose the limited number of days in medicare. In fact, they can be turned back in the hospital and ECF's if they can be taken back to a stepped down type of care.

Staff. Would you favor tighter controls on that?

Mr. Stewart. Yes, sir; very tight.

Staff. What proportion of medicare reimbursement to your members do you believe consists of cost finding and audit and clerical expense above that which the nursing homes ordinarily incur?

Mr. Stewart. Well, the limited number of participations in the medicare ECF program in Arkansas, with 100, as I would like to give

you an example, a 100-bed facility that has four EFC patients and is required to hire a CPA and three consultants, the cost can be 1,000 percent more than the normal course for the rest of the patients. We have to redo our whole accounting system, hire consultants that we need like a hole in the head because they have been there the day before.

The costs skyrocket. We may take a patient and the audited costs, by the time it is spread out over 100 patients, show $13 a day, when the actual cost for that patient was $25 because we had only four patients.

STAFF. Are you finding any abuses with respect to physician ownership in nursing homes? Do you know of any cases where physicians have placed patients for personal gain?

Mr. STEWART. Yes; I do. It is not documented and I would rather not mention it here and call names. It has happened; it happens. I am sorry to say it happened in Arkansas, where a patient is placed in a higher-cost facility simply because a physician owns a part of it.

Senator ANDERSON. If you do have information of that nature, supply it to the committee on a confidential basis.

Mr. STEWART. Yes, sir.

STAFF. Precisely how do you think the Government can prevent discriminatory dealing between related organizations—that is, where a nursing home also is associated with a construction company, with a lending agency, with a drug company, with a wholesale medical supply house, and I am sure that there are a number of other related types of activity.

Mr. STEWART. For the first time, I would rather not field that one with you. I think your staff could much better answer that question than I could. I am not competent to answer that. I can just agree with you that it should not be tolerated.

STAFF. Senator Fannin has proposed a program to finance medical and hospital care through a system of voluntary health insurance. Are you gentlemen familiar with his proposal, S. 2705?

Mr. STEWART. Only vaguely, sir. I do not have it detailed.

STAFF. He has asked whether you would be kind enough to supply your comments for the record after you have had a chance to study it.

Mr. STEWART. We would be happy to, sir.*

STAFF. Those are all the questions we have.

Senator ANDERSON. Thank you very much. We appreciate your coming. I am sorry we interfered with your schedule, but we cannot help the timing of voting.

Mr. STEWART. Thank you, sir.

Senator ANDERSON. Dr. Baker, we would like to have the Cook County Hospital group come forward now.

STAFF. Dr. Baker, the committee desires to have an executive hearing with Cook County Hospital witnesses. That will proceed in the anteroom here at this time.

Senator ANDERSON. Except for that, the hearing is adjourned until Tuesday of next week at 10 a.m.

*At presstime, August 10, 1970, the comments referred to had not been received by the committee.

(There follows, a statement submitted for the record relevant to the preceding testimony:)

STATEMENT OF THEODORE N. ZEKMAN, M.D.

Mr. Chairman and members of the Committee on Finance, I appreciate this opportunity to submit a statement for the record concerning The Associated Physicians of the Cook County Hospital.

Until September of 1968 I was Chairman of the Department of Ophthalmology at Cook County Hospital. I held this position for some fifteen years. The position was purely voluntary and non-remunerative. My tenure as chairman ended when it became possible for the hospital to retain a full-time paid chairman.

My duties as a volunteer, part-time chairman were almost wholly administrative. Primarily I was to assure that there was adequate personnel to cover the needs of the Department. Further functions were to preside at Department meetings to establish general policy, and to assure that the residents in ophthalmology secured proper training and preparation for Certification by the American Board of Ophthalmology. These duties required my presence at the hospital for no more than one afternoon a week. I customarily devoted Friday afternoons to the hospital.

With respect to patient care, I assumed no formal duties. Of course, I was available for consultation on problem cases and I did so consult occasionally. Furthermore, a certain percentage of patients in the Department were allocated to my service and, in this connection, my name would appear on their medical charts. I did not regularly supervise the care of any of the patients in the Department. The treatment of these patients was primarily the function of the residents who were under the supervision of the younger attending physicians in the Department.

I did not supervise surgery nor was I present when surgery was performed during the years 1966–1968 with the exception of one occasion when I personally performed an operation.

In my opinion, the scope and nature of my duties as Chairman of the Department of Ophthalmology was well known to the Administrative personnel at the hospital and to most of the attending physicians at the hospital.

The formation of the Associated Physicians of Cook County Hospital was undertaken for purposes which I then considered and now consider worthwhile. In short, the Association was to collect fees due its member physicians and use the collected funds to promote medical education, research and training, and to improve and widen the scope of available medical treatment at the hospital. At the time of its formation, I received and, I am told, each attending physician received, several documents explaining the concept of the Association. My understanding was that the only way that Medicare funds could be collected without requiring individual billing by physicians would be through the Association.

The idea underlying the Association was attractive to the attending physicians. We were volunteers who secured our positions by competitive examination. There was a tradition of unpaid service at the hospital and we saw no objection to assigning payments to a non-profit organization dedicated to the improvement of medical care.

Accordingly, I assigned to the Associated Physicians all Medicare fees payable for medical services rendered by me. I attended no meetings of the Associated Physicians and took no active role in its affairs other than the original act of assignment.

Early in January, 1969, I received a copy of a letter dated January 2, 1969 to Mr. William B. Sale, Administrator, The Associated Physicians of the Cook County Hospital. The letter stated that the Associated Physicians were indebted to the federal government for a substantial sum of money, and indicated there was insufficient documentation of paid claims. There was also reference to certain unauthorized disbursements. The letter was signed by Leonard J. Allegretti of Blue Cross. This letter was sent to me with a cover letter indicating that claims had been submitted in my name. The cover letter was signed by Walter R. Livingston of Blue Cross.

Shortly after receiving these papers, I wrote a letter dated January 12, 1970 to Mr. Livingston, disclaiming responsibility for claims made in my name. I said: "I did not authorize anybody to submit such claims. Although I did authorize the Associated Physicians of Cook County to collect fees for services I rendered to Medicare patients, I certainly did not authorize the Associated or anyone else to use my name for billing for services I did not render, on which I was never

consulted and which I did not supervise. It would appear that I never rendered any of the services for which the bills were sent to you for payment. To the best of my knowledge, I have not seen or treated any of the patients for which these bills were sent, nor did I perform or supervise any surgical procedures which might or could be the basis for such charges."

It is my understanding that this letter was printed in the Congressional Record of January 26, 1970.

In a letter dated March 12, 1970, Mr. William B. Sale tendered an explanation to me for the submission of claims in my name. The letter indicates that a copy thereof has been sent to the Committee Staff. Briefly stated Mr. Sale quoted paragraph II(B)(2) of the "Principles and Procedures for Billing" which reads as follows: "With respect to the back-log of Medicare cases which may lack written confirmation of the explicit participation of the attending physician in accordance with the above procedure, and, subject to the concurrence of the Director of the Division concerned, it will be assumed that the care of the patient has been under the personal direction of the attending physician (a) indicated in the patient's chart, or (b) the attending physician assigned responsibility for patient care in the area in which services were rendered. With respect to surgical procedures, it will be assumed, with the concurrence of the Director of the Division concerned, that the attending physician indicated on the Operating Room Log Book provided personal supervision in the case of major procedures, and gave his personal direction in other cases."

In his letter of March 12, 1970 Mr. Sale points out that I presided as Chairman at the meeting of the Executive Staff of the Medical Staff of Cook County Hospital at which the principles and procedures were adopted. I was, in fact, vice-chairman of the Executive Staff and I do recall presiding at one meeting. I have no certain recollection that the meeting was on April 9, 1968 nor do I recall acting upon the "Principles and Procedures" at that meeting. However, I have no recollection to the contrary nor do I have any reason to doubt Mr. Sale on this point so I assume that his statement is true.

Finally, Mr. Sale points out that claims were made in my name because: "During the period between July 1, 1966 (the commencement of the Medicare program) and the Fall of 1968, during which time you were Chairman of the Department of Ophthalmology, and therefore responsible for the supervision of the records of that department, over seventy ophthalmological surgical procedures on Medicare patients are recorded in the official operating room records of the hospital as having been under your supervision. Unless the individual medical records of the patients concerned contained specific documentation indicating that surgery was performed under the supervision and direction of another attending physician, it is quite likely that all of these surgical procedures, provided the patient had Medicare Part B coverage, were billed in your name."

Upon receiving Mr. Sale's letter, I reviewed the "Principles and Procedures" and the various papers I received concerning the Associated Physicians. I have come to two conclusions concerning this matter.

First, the "Principles and Procedures" seem to be reasonable and fair except for Paragraph II(B)(2) upon which Mr. Sale relied. It seems to me that the section in question is nothing more than a provision designed to evade the valid principles and procedures expressed in the other paragraphs of the document. Perhaps this particular section should have been subject to closer examination when approved but neither I nor the members of the Executive Staff are attorneys. I doubt that we would have realized the particular problem arising from the presence of this one paragraph in an otherwise fair and reasonable document. Further, the language of the paragraph seems to suggest that its application would not take place on a wholesale basis. The paragraph applies to Medicare cases "which may lack written confirmation" and suggests, to me at least, the implication that most cases would have written confirmation and that a procedure was being adopted to provide for a few, scattered cases. In any event, the assumptions incorporated in the paragraph are and were unjustified. As I stated previously, in my case I did not participate in the treatment of patients on my service except occasionally as a consultant . . . and the extent of my participation was generally known. Other staff members, too, were in the same position.

Second, even under the lax provisions of II(B)(2), it is difficult to see how some of the claims made in my name could be justified. In particular, Mr. Sale indicates that more than seventy ophthalmological surgical procedures were recorded in the official operating room records of the hospital as having been

under my supervision unless the individual records of the patients indicated another attending physician supervised, it is quite likely the procedures were billed in my name. It seems to me that under Paragraph II(B)(2), it is required that the attending physician's name appear in the Operating Room Log Book. It is my recollection that the Log Book should specifically indicate the names of the physicians actually present at the operation. In any event, I am certain that records of the physicians actually present at the operation are kept, and that only such records could form the basis of billing under Paragraph II(B)(2). At the very least, examination of such records would enable an administrator to enquire of the physicians present at the operation the name of the supervising physician.

In sum, I think it would have been better for the Associated Physicians to have foregone collection of fees in cases without sufficient documentation. There was no reason to attempt collection on the basis of dubious assumptions which, in some cases, could easily have been determined to be false. Nor was there any reason why the Associated Physicians could not have at least telephoned each attending physician in whose name a large number of claims were submitted on the basis of Paragraph II(B)(2) and inquired whether the claim was justified. In my case, one telephone call would have established that it was improper to assume that I actually performed medical services simply because my name was typed on a patient's chart.

There have been some allegations of unjustified or improper expenditures by the Associated Physicians. I have no knowledege of the truth or falsity of such matters. But, even if such allegations are clearly false, the fact remains that the Associated Physicians employed careless and questionable procedures to collect Medicare funds. In so doing, they have served to undermine public and legislative confidence in a deeply needed program of government assistance to defray the incredible costs of complex modern medical care.

It is my hope that the serious and expensive problems in administering Medicare will not lead the Congress to repeal or diminish the program. Instead, I would be pleased if the future would see a simpler and wiser method of achieving vital goals that motivated the original passage of Medicare legislation.

(Whereupon at 11 a.m. the subcommittee proceeded into executive session.)

Executive Session

Staff. Senator Anderson, these gentlemen are from GAO. Mr. Iffert and Mr. Rother conducted the audit and investigation at Cook County Hospital for the Comptroller General.

Would you gentlemen please identify yourselves for the record.

Mr. Iffert. Robert Iffert.

Mr. Rother. Joseph Rother, Assistant Director, Civil Division, General Accounting Office.

Mr. Layton. Fred Layton, Assistant Director, Civil Division, General Accounting Office.

Staff. On February 23, 1970, the Board of Directors of the Association passed a resolution recognizing the amount of medicare overpayments as $1,109,000 and agreed to make an immediate refund of $300,000 in partial payment. The remaining $809,000 was to be recovered from partial withholding of future payments due on pending and current claims over a period of not to exceed 36 months. In view of the recent newspaper publicity indicating that services at the Cook County Hospital may be curtailed, where are the funds going to come from to repay the balance of $809,000?

Mr. Sale. Well, Mr. Chairman, the exact amount of overpayment is still a matter to be verified between SSA and ourselves. We do not agree on their system of statistics and it may be $800,000 instead of $1,109,000. We are engaged in a dialog with Mr. Levine of SSA. However, that still would leave, if it were eight or nine, that would still leave a considerable amount of overpayment to be repaid.

We have about $700,000 in claims that the carrier has been holding since payments were suspended a year ago which are now being processed. These will be subject to the same kind of discounting as the one million six was because of lack of documentation.

We also have about 500 claims for services rendered between the suspension of our submission of claims and June 1, when the new guidelines went into effect, which we have now completed and submitted in accordance with the special documentation rules set up by Mr. Levine saying that SSA will allow this, will not allow that. So this category of claims is all documented and this has a value of $37,000, less the deductibles and coinsurance.

We have in the house, so to speak, about 5,000 or 6,000 claims since last June, which are much better documented, particularly in the later months, and will have a higher net yield. I do not know that it will be, but if the 500 claims that we were holding and have submitted and documented are worth $37,000, the 5,000 or 6,000 claims should have a gross value of over $400,000.

STAFF. Would all of that add up to the $809,000?

Mr. SALE. No, it will not, however, repayment is to be made over a 3-year period.

Senator ANDERSON. What figure would it add up to?

Mr. SALE. It is hard to say, sir, because we do not know just what the documentation is. But it is much better.

Of course, if we had 100 percent documentation for all services of attending physicians, we would be paid 100 percent. For the services that are being rendered currently, I would estimate that there are over 50 percent adequately documented.

Senator ANDERSON. Concerning the $1,100,000, was that not a firm agreement with Social Security?

Mr. SALE. It was subject to verification, as you see in our resolution, which was accepted as the basis for settlement.

Senator ANDERSON. Was that considered a maximum amount, or could it go higher?

Mr. SALE. It could not go higher.

Senator ANDERSON. But it could go lower.

Mr. SALE. Yes, as a result of review or verification of the method used by SSA for determination.

Dr. COLLINS. Your question might refer to a curtailment of hospital admissions, presumably, at the present time. This could effect current and future medicare income.

STAFF. That is right, because of the medical staff problems.

Dr. COLLINS. But that is likely to be resolved. There is no question that county hospital will be here when we are all dead. The fact is operation of the hospital will continue although it may be under a different authority. That is all that is at issue, really.

STAFF. There may conceivably be a change in the statute which puts a stop to all teaching physician payments.

Could I ask one question of you and the General Accounting Office.

Is the General Accounting Office maintaining a continuing surveillance of the negotiations that are going on between the Cook County physicians and the Social Security office in Chicago?

Mr. ROTHER. No, not at the present time. Up until the time we issued the supplemental report, we did, but we are not now engaged

as actively in the monitoring of any negotiations that are taking place between the Association and the Social Security Administration.

Mr. SALE. I might say that—I think this is correct—we are not making new appropriations.

STAFF. You do not have anything left.

Mr. SALE. We have a little left.

Dr. BAKER. He did not mention our current assets.

Mr. SALE. You did not ask.

Our agreement with Social Security provides that a percentage of the net income from current and future billing will be withheld and a percentage will be given to us to allow for not only operating expenses but also it was envisaged we could carry on a minimal program of assistance to the hospital, mainly to the staff, in order to keep up morale and keep things going.

Aside from that, I believe we have no plans for any other expenditures. Also, I might say that the agreement with SSA provides that SSA will make the determination as to what percentage will be allowed us, say out of this $37,000. If it is all good, less deductibles and coinsurance, they will determine or make some estimate about what our future income might be in order to liquidate the entire debt over a 36-month period.

Senator ANDERSON. The debt is about a million dollars?

Mr. SALE. It is about—$300,000 has been paid, Senator, so it now is 700 or——

Dr. BAKER. $809,000.

Mr. SALE (continuing). Or possibly $600,000, depending on verification of the statistical method used by SSA.

STAFF. The Internal Revenue Service has announced that in the case of payments like this—that payments made in the name of a doctor for services rendered by a doctor ought to be treated as income to the doctor and he is to get a charitable contribution deduction for making the gift back to the association.

Mr. SALE. As you probably know, there are three kinds of rulings. There is one covering a situation where the doctor is not able himself to receive benefit from the fees earned—that is, he could not bill for himself. He can assign his right to fees to a nonprofit association or the medical school or the hospital. The regulations of the hospital or the medical school do not permit him to receive benefit himself. In that case, he need not declare the income as part of his gross income.

There is another situation where he could, if he wanted to, receive it himself—but he has voluntarily turned it over to a nonprofit institution. In that case, he can deduct it as a charitable contribution.

There is another case where he can deduct it as a business expense.

STAFF. The right to assign income does not have anything to do with the statutory requirement that he report the receipt of income. By having the right to assign income, he has the right to beneficial enjoyment and he has exercised the right of beneficial enjoyment by assignment.

Mr. SALE. There are prior rulings for the University of Illinois, which is our neighbor, where the doctors are not, according to the rules of the hospital and the medical school, permitted to receive the money themselves. In this case, it has been ruled that they need not report it as part of their gross income.

STAFF. So you are relying on a private ruling decision in another case?

Mr. SALE. We are hoping to get a ruling of that kind.

STAFF. You have an application for that ruling in?

Mr. SALE. Yes, sir; and we understand it is to be ruled upon momentarily.

Dr. BAKER. If I may mention it, the rules of the hospital for many years have been such that no physician is allowed to bill for services which he provides the hospital. As a matter of fact, it specifically is interdicted.

For a number of years, another fund operated by Hektoen Institute of Cook County Hospital has billed insurance companies in the names of various sundry physicians for their services without this ever incurring an income tax problem. So we feel that within our own institution, there is a precedent and, of course, the ruling has been applied for.

Mr. SALE. I might also say that Los Angeles County Hospital and the medical school there have an agreement whereby all of the doctors assign their right to fees to the school.

STAFF. But that is a condition of employment, is it not?

Mr. SALE. Yes.

STAFF. The IRS made a distinction in their ruling between where the assignment is made as a condition of employment and where it is done on a voluntary basis, as it was at Cook County.

Dr. BAKER. Well, when a staff physician is appointed at Cook County Hospital, he agrees in writing to accept the rules and regulations of the executive committee of the hospital. One of the rules and regulations of the executive committee at Cook County, whether he is salaried or not, is that he not be allowed to bill for the fees that are theoretically due him.

STAFF. But has he assigned the fees?

Dr. BAKER. He does when he joins the association, and he cannot bill or collect for himself.

STAFF. Then that is a voluntary thing.

Mr. SALE. I believe there are some instances at Los Angeles County, too, where fees are not assigned.

Dr. BOUER. I am Dr. Bouer, president of the medical and dental staff—the physicians and surgeons fund of the Hektoen Institute, which was collecting private insurance fees, did so, as far as I know, without assignment, simply billed for doctors giving services at the hospital, and none of us who were on the staff before establishment of this association of physicians ever recall having signed an assignment for that organization.

STAFF. Some of those hospitals are being looked into, also.

Dr. BAKER. This was our own.

Mr. IFFERT. Some of the bills we saw, the doctor didn't even put his name down. He just said for professional services and the insurance company paid him.

Mr. SALE. That is for private insurance?

Mr. IFFERT. Yes.

Mr. SALE. That is the way my personal doctors do it, just for services rendered.

Mr. IFFERT. He didn't even sign it.

Dr. BOUER. But the physicians had not made assignments.

Mr. SALE. This authority to collect fees for the benefit of the hospital was delegated to the director of the Hektoen Institute by the executive staff of the hospital in 1958 or 1959.

STAFF. Mr. Sale, before you went to Cook County Hospital, you had been involved in billing for medicare payments for services of supervisory and teaching physicians at Bellevue Hospital, New York City?

Mr. SALE. Yes, sir.

STAFF. Were the billing procedures established at Bellevue similar to the arrangements established at Cook County Hospital?

Mr. SALE. Exactly the same.

STAFF. Also, were the circumstances under which patient care was provided the same at Bellevue as at Cook County?

Mr. SALE. The same, except at Bellevue, initially, there were three medical schools involved. There is one other difference in the organization of the two hospitals. At Bellevue the director of surgery, for example, is chairman of the department of surgery at the N.Y.U. Medical School and is paid by the school for both jobs. At County, where we are affiliated with fine medical schools the Bellevue arrangement would not be feasible, so the administrative salaries are paid by the hospital. I was only doing the billing and collecting for the New York University Medical School Professional Service Fund. And when I came to Chicago, in my initial contact with the SSA office and the carrier, in my letter of March 1, which is an appendix in your green book here (page 404, hearings of July 1 and 2, 1967), I suggested that the procedures which have been established at Bellevue and approved by the carrier representative there, Dr. Safian, and by the regional SSA representative, Mr. Godfrey, be adopted in our case because the situations were so similar. After consultation or discussion or telephone calls with Baltimore, they were told—this is my understanding—they were told yes, Bill Sale has established a program and it is working very well, and go right ahead.

STAFF. Has the association made any changes with respect to billing for services of supervisory or teaching physicians at Cook County Hospital and have social security and blue shield examined into and agreed to such changes?

For example, we understand that the Cook County Board of Commissioners has determined that the salaried physicians at the hospital are being fully compensated for the care of patients, that their salaries include payment for the care of patients.

Mr. SALE. If I may, concerning the resolution of the county commission, as you probably know, we have been having a running battle with the county board of commissioners over the past 2 years to get their agreement, or their blessings, as we did not feel we needed their agreement, to our billing. They could have told us to stop, because they were in control of the hospital.

As of October 11 the new Cook County Hospitals Governing Commission became the governing body of Cook County Hospital under an Illinois statute which gave them the responsibility for managing and operating the hospital and establishing the budget and establishing fees and collecting them for hospital services. So in my opinion and the opinion of our attorney and the opinion of members of the govern-

ing commission, the resolution by the county board of October 20, after they ceased to be the governing body of the hospital was really without effect respecting our situation.

Dr. Bouer. Leaving aside the difficulties that exist between the Cook County Board of Commissioners and the Governing Commission of the Cook County Hospital which, as you have followed in the papers obviously, are in direct conflict in terms of questions of control and financing management of the hospital; I would add that there are physicians in the hospital who, by the nature of their duties, are salaried for administrative services, such as the directors of divisions and chairmen of departments and their deputies. There are also physicians who do not have these full-time administrative duties who are paid by the hospital or one of the affiliated medical schools for their teaching and supervisory services, who are primarily involved in providing supervision and direction to the interns and residents, and this, of course, involves patient care. The physicians who direct and control departments and divisions also have separate appointments as nonsalaried attending physicians. These physicians have administrative responsibilities that are so extensive as to take up all of their regular salaried time; any time that they are caring for patients is above and beyond that for which they are paid for their administrative services.

We have had several examples of individuals who were working as volunteers at the hospital whose time with patients was totally compensable in term of collection along these lines, who then later came in and took a full-time job and continued to take the same care of patients but were being salaried for their full-time job. However, our recently resigned medical superintendent, director of the hospital, Dr. Freeark, who was formerly chief of surgery, was paid a salary relating to direction of the hospital. On occasion, he went to the operating room, certainly above and beyond his duties, because the previous director of the hospital was not a physician and could not have gone to the operating room. It is my contention that when he went to the operating room, he was doing so as surgeon of the Cook County Hospital under his previous civil service arrangement, not as director of the Cook County Hospital, which was 40 hours a week.

Staff. In the association's letter of July 16, 1969, which was attached as an appendix to the comptroller general's report of September 1969, there seems to be considerable emphasis on the phrase, "supervision and direction of interns and residents in the care of individual patients." The meaning of this was not clear, because supervision and direction can be a direct and personal arrangement or it can be a rather indirect and remote arrangement.

For example, it could be argued that as director of the hospital, Dr. Freeark provided supervision and direction with regard to the care furnished all patients at the hospital and that all medicare bills could have been submitted in his name as the patients' physician.

What's the definition of "supervision and direction"?

Dr. Baker. Let me answer this, because I had an opportunity to debate this with the Illinois Medical Service and Mr. Levine of SSA.

Our definition of direct supervision is based on the assignment of a patient to a given service or physician, so that if the patient comes in on Dr. Jones' service, Dr. Jones is responsible for the patient's care

unless another physician assumes responsibility for that patient. But under no circumstances would an administrative director of a hospital be able to assume responsibility for a patient's care because he has no legal authority to do so. Furthermore, if malpractice were to occur—of course, it never does at our hospital, but if it did, the physician who is sued would not be the director of the hospital. The physician who would be sued would be the physician who would be legally assigned to that patient's care. He is the one who is required to assume supervision.

Dr. Collins. I would like to respond to that previous question. As an attending physician in the division of anesthesiology, I have an opportunity to see the surgeons at work. The surgical work by a resident is not done except that an attending physician directs him to do the work.

Staff. In person?

Dr. Collins. Not always. It may be immediate, with the attending physician physically present or it can be by outlining the procedure that is to be done and if the attending physician considers that the resident is competent technically to carry it through according to the program of treatment that is outlined surgically, then it is carried through in accordance with the direction of the attending.

Dr. Bouer. I would like to further answer that. I happen to come from the department of obstetrics. I am a volunteer at county hospital and I am in the obstetric department. I am also aware that we have no medicare patient who delivers babies after age 65. However, I can also tell you that no cesarian sections, no ectopic pregnancies or any other operations by our department at Cook County Hospital are performed without an attending physician present, scrubbed.

Staff. That is not true in——

Mr. Sale. It has always been true that medical care is rendered under direction of an attending.

Staff. Did not the GSA find that there were no physicians present who were scrubbed?

Mr. Iffert. They were not shown as present.

Dr. Bouer. We did have fourth and fifth year surgical residents who, having completed the major portion of certification of boards, were considered to have surgical privileges and who were supervised at greater distance. On the other hand, we also have a documentation problem. Our's is one of the few hospitals which unfortunately does not have dictating facilities for attendings to dictate reports and notes that modern hospitals have. It was necessary to sit down at a typewriter or do it in longhand and sign it yourself. This has been a tremendous impediment in terms of our recordkeeping. I know that our recordkeeping is not your problem. I am aware also that a fine record is important evidence of good medical care, because you cannot prove it otherwise, not only in terms of billing but in terms of followup or anything else.

On the other hand, those who are at county hospital recognize that the recordkeeping problem was a problem and that we did not have the modern facilities that others have. When I am in a private hospital, I sit down after an operation, pick up a telephone, dial a number and dictate my operation. They type it out for me and the next day it appears on the chart and I sign it. This was not present at Cook County Hospital.

I think that the failure to have documentation of the presence of a physician there was not necessarily evidence that a physician was not there.

STAFF. Well, we have your recruiting brochures for interns and residents. In the general surgical resident's responsibilities, the description of his role says, "The second year resident performs many and varied operative procedures," which apparently medicare was expected to pay a supervisory physician charge for.

"The third-year resident serves as a senior resident with independent operating privileges."

Now, what are "independent operating privileges"?

Dr. BAKER. This would mean that if a patient were admitted with acute appendicitis at midnight, the resident would consult the senior attending staff man in the hospital, Dr. Norcross, and discuss the case with Dr. Norcross, and say the patient has acute appendicitis. Dr. Norcross would say, go ahead and if you have any problems, call me.

Dr. Norcross slept in the hospital and was frequently not in the operating room for standard operations which would be compatible with a third or fourth year resident's training.

STAFF. It says the fourth-year resident performs more than 500 operations?

Dr. BAKER. That is correct.

STAFF. And medicare paid the resident's salary?

Dr. BAKER. That is correct. The 500 operations he performed were in many instances—not entirely in all instances—what we call "staffed." He had a staff man in the operating room, crubbed or not scrubbed. Sometimes the staff man would come in. If it was a procedure the resident had performed 20 or 30 times before, he would say, how are you doing , fine? And if there were no problems, he would go out.

STAFF. How much did you bill medicare in those cases, three and four hundred dollars?

Dr. BAKER. Yes, they were billed for the surgical fee.

Mr. SALE. This is a gray area. There is lack of clarity in the guidance provided by SSA and by the Federal regulations that has been a cause of great concern to me from the very beginning—just what did the regulations mean? The regulations provided that the attending physician would be reimbursed, was entitled to reimbursement for his direction—not just for what he did or what he personally supervised. Then the regulations go on to state that in the case of major surgery or dangerous procedures, he must be present in person. I interpreted this as meaning that if it were not major or dangerous, he could give his direction and say, go ahead and do it because you know how to do it.

But the attending physician who was responsible, legally and ethically, was entitled to reimbursement. And this was the interpretation that I put on it. This is the interpretation that is contained in our principles and procedures for billing that we established at Bellevue and then was adopted also at Cook County.

STAFF. You are familiar with the documents on the presence of the physician and compliance with the regulations concerning billing for surgical procedures. What did you find in Cook County?

Mr. ROTHER. There was a documentation problem at least. There is no way other than by reviewing the available records that we would have to determine whether or not an attending physician was present in the operating room.

Our comments in our report were based on our review of the records, which showed in many instances no evidence of an attending physician present in the operating room at the time that the surgery took place.

STAFF. For major surgery?

Mr. ROTHER. How do you define major surgery?

Mr. IFFERT. Dr. Freeark was probably outstanding and all the cases we looked at, there were only two he considered major. There were a lot of amputations. I am not a doctor.

STAFF. Did you find any of the attendings who were off on the day when the surgery was performed?

Mr. IFFERT. We do not know when they were there.

STAFF. Is this question of the presence or the absence of the supervisory physician part of the $300,000 difference in what the overpayment might amount to?

Dr. COLLINS. No. This is statistical.

Dr. BAKER. It is a statistical interpretation of the data available; that is, the determination of the value of the 10,000 claims paid on the basis of 75 claims audited by GAO.

STAFF. In the negotiations, you do not have this as an issue?

Dr. BOUER. No, we accepted it to be a guideline change that could be appropriate for future billings. We are not really disputing this. We say that the documentation was not as good as it should have been by any stretch of the imagination. We are saying many of the physicians were present and failed to get documentation on the record.

We also have another problem and that was that the physician whose name was on the record was dictated by periodic schedules of ward appointments from the civil service lists of attendings.

For example, the fact that a physician may have taken a 3-month vacation did not keep patients from being admitted in his name for that 3 months, because the rotation of patients coming in was assigned downstairs in admitting according to ward schedules and the physician whose name was assigned to the patient was not by any stretch of the imagination always the physician who was actually in attendance.

STAFF. Then where is this question of legal responsibility? Was that physician on vacation whose name was put on bills for 3 months and whose name was put on in the admitting office? Was he legally and ethically responsible for the patient's care?

Dr. BAKER. No.

STAFF. But he was listed as the attending physician.

Dr. BAKER. Yes, on the admission sheet. We are not arguing, I hope, the quality of the medical records. We are discussing who is responsible for the patient's care if Dr. Jones is on vacation for 2 months. When Dr. Jones left the hospital, what he would do is notify the department chairman. The department chairman would assign an alternate attending and that alternate attending would assume the responsibility. The alternate attending should, and if he had known then what we know now, would have put a note on the chart as often as he attended.

But they come in and they have 20 and 30 patients for whom they are responsible. They actually spend a great deal of time with the very sick ones. If they put a personal note and signature on the 20 or 30 charts, it would take a lot of time away from care of the very sick ones.

When I make rounds in a private hospital, a nurse walks behind me. I tell her, write down that the patient should have such and such, and she does. I sign it when I go back to the desk.

At the University of Illinois where I attend, the same situation pertains, except that the intern puts down the notes which I endorse on the charts. I rarely write a note on all charts.

Dr. BOUER. I think, as an example, getting back to my department, in our peak year in our obstetric department at county hospital, I think we delivered 19,000 babies. There was only one fulltime and one halftime doctor at county, the director and associate director of the division, so the entire care was by volunteers. If my assignment is one of nine attendings for 19,000 patients, it would have represented several thousand patients in addition to my private practice. I would not have much time to sleep. As a result, the attendings came in at the various hours of the day and night for their time and took care of everybody's patients. In other words, the attending physician present handled all the patients. It did not make any difference whose service the patient was on.

I have the feeling that your question about legal responsibility means should there have been a law suit and my name appears on the chart, I probably would have been a party in that law suit as well as the doctor taking care of the patient, as well as the anesthesiologist and probably the hospital as well, because the tendency in these legal claims you are talking about is to involve anyone who appears in the record.

STAFF. No, we meant that in a higher sense, in the lofty way in which it is presented about the supervisory physician being legally and morally and professionally responsible and so on.

Dr. BOUER. But I do think that you have to——

STAFF. How many malpractice suits have been filed against supervising physicians at Cook County Hospital?

Dr. BAKER. No more than one or two, to my knowledge.

STAFF. Against the supervisory physicians?

Dr. BAKER. Against any physicians.

STAFF. He said teaching physicians.

Dr. BAKER. When any suit is filed, it is always filed against the supervisory physicians.

STAFF. No; it is the attending. I am talking about the supervisory physician in the medicare sense.

Dr. COLLINS. We have a suit against myself as the anesthesiologist for a broken tooth done by a resident. How far it is going to go, I don't know, but I am the one.

STAFF. Was it a medicare patient?

Dr. COLLINS. No, but it could have been. The patient was about 56. He was not entitled to this, but nevertheless it is an example of the situation in which I was the responsible individual although not immediately present at the time the accident occurred.

I would like to confine just the matter of supervision in terms of just the actual performance of the surgical procedure. Most of the services for major surgery require that there be an attending either on the floor or in the operating room, not necessarily scrubbed. We have a rule in the anesthesia department that for all major surgery, my resident—and for example, no gynecologic case is done without

an attending doctor there—my anesthia staff will not begin an anesthetic until the attending reports that he is present somewhere, either in the operating room or on the floor.

Dr. BAKER. This is really a universal teaching hospital practice, as I am sure you know. This is not unique with us. We did not devise the system of residency responsibility.

STAFF. No; that is the significance of it. The point is who is doing the work, the basic work? In one case, you have the contention which the staff made in its report that essentially, the residents and interns literally do the gut work.

Dr. BAKER. They do the manual work.

Dr. COLLINS. They could not do it without——

Dr. BAKER. I do not think any teacher will accept the fact that a resident, regardless of his seniority, does the "gut" work in the sense of making decisions or seeing to it that the patient is properly cared for.

STAFF. Here is what it says in your recruiting brochure.

Dr. BAKER. I did not write that.

Dr. COLLINS. There is a concept in teaching of graded responsibility.How else are we going to get manpower and physicians?

STAFF. That is not the point. The staff's contention was that no matter how you slice it, it is essentially a teaching function. It involves clinical care to a greater or lesser extent with individual patients. That is all, but it is essentially a teaching responsibility with respect to interns and residents.

Dr. BAKER. I don't think you can separate it.

Dr. BOUER. I not only accept that that we said in our brochure, but let me say also——

STAFF. You did not say that in your brochure, we said it in the report to the committee.

Dr. BOUER. All right. Let me say that the boards require that the resident in a surgical specialty—in a medical speciality, too, but in medicine, we question about who can care for a patient—but in surgical cases, the boards require that the primary responsibility be given to the surgical resident if he is to receive an accredited training, to let him go out and practice medicine; and that for him to become a specialist and become board certified requires that at a certain point in his training he be given the primary responsibility for patient care. This does not mean that he has the real responsibility in the sense of legal and moral responsibility for the patient's well-being, but he must be doing a certain amount of surgery to be considered to be accredited for a good residency.

STAFF. I do not think our quarrel was with that. I think the quarrel was with the——

Mr. SALE. I think one of the most important factors in this whole dialog between your committee and the association——

STAFF. It is not a dialog between the committee and the association; it is a dialog between GAO and B.H.I. and the attempt to recover funds erroneously paid.

Mr. SALE. Yes. The GAO, as they recognize in their report to you, were answering specific questions. They were not evaluating our performance under the law. You asked them who performs what?

On the other hand, the law of the land says, Federal regulations which are still in effect despite the revised guidelines, payment on the basis of reasonable charges is applicable to professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns and residents who are participating in the care of his patients.

STAFF. And which consists of ——

Mr. SALE. You have a team. Then it goes on to talk about surgery, about during dangerous procedures they must be present. I assume, therefore, that in nondangerous procedures, they did not have to be present. They just had to give direction and we could still bill for the full amount.

It goes on to say that he will demonstrate the fact that he is the attending by such things as the following—examining the patient, reviewing the history, approving the diagnosis that has been made in the first instance by the intern.

STAFF. Precisely how did you verify that each of the attending physicians whose name you billed rendered exactly those services?

Mr. SALE. This is the practice.

Dr. COLLINS. The procedure would not have been done. Let's put it another way, if there were no attending physicians, if I were not on the staff with three other anesthesiologists, there would be no residents, period. Therefore, the residents can't do anything without the knowledge that they are under the jurisdiction and the supervision and the immediate consultation and the availability of an attending staff.

STAFF. What I was talking about were those criteria. Granted that you have attending physicians, how did you verify that in fact, those criteria were compiled with in the case of each individual medicare beneficiary for whom you submitted billings and that a visit was made to that patient in every single day? Did you not hire medical students and dental students, hire them to make those notations on the medical records?

Mr. SALE. First I want to explain that we used students to abstract billing information from the patients' charts. Under no circumstances could they make notes in the charts. I was not able to get clarification as to just what the requirements were from Dr. Safian, from Mr. Godfrey in New York, or from anybody here. So I wrote up my own understanding of the law, the principles and procedures for billing.

Now, the principles state, which is in the back of your green book (page 406, hearings of July 1 and 2, 1969), state the situation as it is—that is, in teaching hospitals, every patient is assigned to an attending physician. The attending physician sees him, he is legally and ethically responsible for the care. He gives direction to the interns and residents. No medical care can be rendered to a patient in a teaching hospital without supervision and direction.

It does not mean personal, at the moment, but direction.

STAFF. Oh, sure. No quarrel with that.

Mr. SALE. So I interpreted it this way and this was accepted. It was not until last April when the new guidelines came out that there was the first mention of documentation requirements.

Now, with respect to individual visits, in New York, I asked Dr. Safian, what do you require in order for us to bill for daily care? He said bill for every day that the patient is in the hospital.

STAFF. Do you have that in writing from Dr. Safian?

Mr. SALE. No, not specifically, in writing.

STAFF. That he said to bill for every day that the patient is in that hospital?

Mr. SALE. I think I do have correspondence confirming this.

Dr. COLLINS. While he is looking for it, I think the greatest verification of the fact that a patient has received treatment is the fact that the beneficiary is the one who determines whether or not he has been treated. What I am saying is when a patient comes into a hospital, in our hospital particularly, he is usually sick and in the course of staying in this institution, he either comes out of it having been treated and is alive, or he is not.

STAFF. Well, medicare pays either way.

Dr. COLLINS. Even if he is dead.

STAFF. That is the biggest difference between the medical profession and the legal profession—you bury your mistake and they have to face theirs.

STAFF (continuing). And medicare pays in both cases.

Dr. COLLINS. I would like to respond before it is lost in these newer questions to a question that you raised a little while back. That is in regard to the appointments of the attending physicians.

Now, the question is a very simple one. This is the concept of two hats. Most of us who are on a stipend wear two hats. I wear a hat, and so do some of the surgeons, that is recompensed by the Cook County Board of Commissioners at the present time for teaching and administration. For an 8-hour a day 5-day week, nothing more, that is what I get my stipend from Cook County for, as director of the division of anesthesiology. Anything over and above and beyond that, if it involves my administration of an anesthetic or my supervision of it, is patient care, in my second capacity as a member of the attending staff. For that, I am not recompensed.

I wear the second hat by virtue of a Civil Service examination as an attending doctor. I also hold in terms of the first hat, another Civil Service Commission as director of anesthesiology. The job specifications for this and other full-time jobs are quite clear right down the line. There is nothing that specifically says that I am there to provide patient care. Ninety-nine percent of it says that I am there to administer and to teach.

I want that very, very clear.

Mr. SALE. With respect to Dr. Safian, what I do have is a memorandum to Dean Lewis Thomas, who was then Dean of New York University School of Medicine, and my boss, reporting on a meeting with Dr. Safian on July 19.

STAFF. This is your memorandum?

Mr. SALE. Yes (reading from document).

During conversation, Dr. Safian informed me that with respect to value scale of medicine, we could use a medical value scale adopted by the State of New York, which is from California. He said that UMS—United Medical Service—would honor requests from reimbursement based on this scale times a factor of $7 with every in-hospital day considered as a visit regardless of evidence or lack thereof on the patient's chart.

Then on October 25, I have a letter—after more negotiation.

STAFF. What year is that?

Mr. SALE. Sixty-seven.

STAFF. Could you provide that for the record?

Mr. SALE. Yes.

This says thank you for sending me, et cetera.

STAFF. On that basis, we had a question here that relates right to that.

Mr. SALE. I can give you this whole file.

STAFF. Fine.

(The material referred to follows:)*

NEW YORK UNIVERSITY MEDICAL CENTER,
BELLEVUE PROFESSIONAL SERVICE FUND,
July 19, 1967.

Memorandum
To: Dean Lewis Thomas, M.D.
From: William B. Sale.
Subject: Medicare Fee Schedule—Interim Report.

Since our meeting of last week I have had some telephone conversations with Dr. Safian on this subject. I had wanted to get clarification of his "offer" and also find out what progress was being made on lining up other institutions.

Dr. Safian confirmed that he believed that a conversion factor of 5.5 for Surgery and 7 for Medicine represented a "reasonable" charge for services in the "teaching setting"—I again, without any apparent success, reiterated our view that the regulations provide for reimbursement of a reasonable charge based on the physicians' customary fee *outside* the teaching setting. He complained that our proposal to submit service-by-service uniform fee schedules based on the average customary fee would be administratively unworkable from this point of view. I said that we were going to complete our survey anyway, to try to determine what the fee should be on the basis of the rules set down in the regulations.

During the conversations, Dr. Safian informed me that with respect to the relative values for Medicine we could use the "Relative Value Scale" adopted by the Medical Society of the State of New York (First Edition, 1965) rather than the NY State "Medical Fee Schedule" prepared for Medicaid reimbursement. He pointed out that the Medical Society provisions for Medicine were considerably more generous than NY State allowed for initial visits and for consultations. He said that UMS would honor requests for reimbursement based on this scale, times a factor of $7, with every in-hospital day considered as a visit regardless of evidence (or the lack thereof) in the patients' charts.

On the basis of the above understanding with Dr. Safian, I have prepared the attached schedule of charges for visits and consultations. If these charges are close enough to the "consensus" regarding a "customary" fee for such services, we may be able to settle this part of the fee problem without further ado.

P.S. Dr. Safian told me that so far the following had agreed to the "5:5—7" factor formula: St. Vincent's, Special Surgery, Downstate, L.I. College Hosp. and "probably" Montefiore. He observed that "because of the relatively high customary fees of many of their doctors", which were higher than the "prevailing rates", P & S and Mt. Sanai were holding out for a higher schedule.

STAFF. In your recruiting brochure of which Dr. Baker disavows any authorship, it says that at Cook County the intern is given a large measure of responsibility in patient care. He is first to see the patient, takes the history, et cetera. The intern makes the initial diagnosis and differential diagnosis. All his decisions are subject to review and endorsement within 24 hours by the intern's resident and further review thereafter by chief resident attending.

Dr. COLLINS. So what's new.

STAFF. We are not quarreling with that.

Dr. BOUER. Let him finish. He has a point.

STAFF. We found similar statements in other teaching institutions.

If the intern performs all those tasks which are reviewed by his resident and perhaps reviewed again by the chief resident what did

*See p. 760 for a reply by Dr. Safian to the memorandum of William B. Sale.

the attending physician do to justify a charge at Cook County Hospital of $21 for an initial visit, which purported to consist of a patient history, physical examination, and diagnosis?

Dr. Baker. I think what you are doing is taking a selling item to a very, very difficult group to recruit and interpreting it a little too literally, if you do not mind my saying so. It is akin very much to a personnel manager trying to hire an executive and telling him a lot of things, 99 percent of which is true and 1 percent of which is——

Staff. Are you saying this is puffed?

Dr. Baker. No; I am not saying "puffed." I object to that term. I am saying it is an intern's eyeview of an intern service. Because the intern, who is in such short supply in the United States these days, has to be attracted by what he thinks is a highly romanticized view of his role in patient care.

Now, I will not deny that, in many instances, he does provide the initial care. But the resident oversees him and the resident is responsible to, and is overseen by, the attending.

Staff. Right. So medicare pays on a cost basis for the first, A, and B, the intern and resident, and then, C, the attending is the one who makes the big money.

Mr. Sale. Because he is responsible.

Staff. Yes; OK.

Mr. Collins. He is the only one who has the knowledge that filters down to the high school level.

Staff. That responsibility, we were saying, and I believe you will agree, will vary from patient to patient.

Dr. Bouer. Well——

Dr. Collins. That is right.

Dr. Bouer. I would say this is not greatly unlike the doctor in his office having a nurse give you a shot. I do not give shots, so I am not really going to say that I do that. But I would say that it is done and it is a practice and people do accept this.

I would say if there is some poetic license used in attempting to recruit house staff in this highly competitive market——

Staff. It is also highly universal. We found it in virtually every brochure.

Dr. Collins. It is in private institutions.

Mr. Sale. Sir, I think this might be helpful. This is from the AMA Judicial Council of Opinions and Reports. This is their 1966 edition. They made a mistake and used the old plates so had to have an errata in it which is very interesting.

In connection with the question of payment of physicians for services performed by interns under his direction or supervision—now, this one was the pre-1966 version of professional ethics which never change. It is just the wording that changes according to the preface.

Staff. And the billing.

Mr. Sale. No.

Dr. Baker. This was before medicare was even thought of.

Mr. Sale. As a matter of fact, the effect of this change was to cut down on the amount of billing that attending physicians could do. But this shows the two philosophies, I think, if you will let me read this, this is the pre-1966 version:

The council agreed that if a doctor assumes responsibility for the services rendered to a patient by an intern, the doctor may ethically bill the patient for the services rendered by the intern under his direction and supervision. The intern is the agent of the doctor for whose action the doctor is liable. In providing instructions to the intern, in assuming responsibility and in accepting liability, the doctor performs a service for which he may ethically bill the patient.

Now, this is the way I interpreted the requirements of Federal regulations (title 20, ch. III, pt. 405, subpt. E).

Now, in 1966 this provision of the AMA "Principles of Medical Ethics" was changed to read:

The council agreed that when the physician assumed responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction and supervision.

STAFF. How many of the patients were billed? I think that says you can bill the patient.

Mr. SALE. Well, I think this is——

Dr. BAKER. In private hospitals, all of them.

STAFF. No, sir, that is not so. But I ask you how many medicare beneficiaries in Cook County Hospital recognized and acknowledged the teaching physician, the supervisory physician, as their attending physician, signed a claims form themselves, and understood that they were liable to that physician for deductibles and coinsurance amounts? In how many cases did individual beneficiaries understand that you were billing three or four hundred dollars for services provided to them by supervisory physicians?

Mr. SALE. These patients could not understand that.

STAFF. Did any of them get a bill? Did you ever submit a medicare bill to a patient directly?

Mr. SALE. Getting back to the signature.

STAFF. The AMA says the doctor may bill the patient.

Mr. SALE. Isn't that what we are doing? Do we have the assignment?

STAFF. Did you have a bill? I want to pursue that. I want to pursue it in this sense: lawyers bill for the services of their law clerks. But what we are concerned with here was in how many instances did teaching physicians bill for their services, say, before medicare and after medicare?

Before medicare, did you bill patients for the services of the teaching physicians?

Dr. BAKER. Yes.

Dr. COLLINS. Yes.

STAFF. Do you go to the insurance companies and bill insurance companies?

Mr. SALE. Since 1959.

Dr. BOUER. That is what the physicians and surgeons fund was, sir.

STAFF. Do insurance companies commonly pay these claims or resist these claims?

Dr. BAKER. $750,000 a year was paid, as best we can tell; we are not sure.

Mr. SALE. In your green book, there is a listing of companies that did pay, and only this many who did not and this many who did (indicating).

STAFF. To the extent that they had insurance. Cook County, as I understand it, before medicare, billed if the patient had insurance and you billed the patient. The patient, if he had a policy with Mutual of Omaha, had the obligation to pay you or the Hektoen Institute. That was indemnified.

Mr. SALE. Bills were submitted to the companies and paid to Hektoen on the basis of the patient's assignment.

STAFF. Some insurance companies take assignments; others do not.

Mr. SALE. There were all assignments.

STAFF. But the patient signed.

All we are saying is every form we have seen from Cook County Hospital says, "Patient's signature on file."

Mr. SALE. This is explained in my letter to Mr. Heitzman, it is on page 394 of the hearings. When I came into county, the director of the Hektoen Institute, who thought that the physicians and surgeon's fund was going to be able to collect medicare and medicaid as well as private insurance, had been getting patient's signatures—that is, when the patient was admitted, it was part of the admission procedure that he would sign an assignment of his hospital insurance to the hospital and medical insurance to the doctor. This is what I do when I go into a hospital. I sign the insurance form assigning my insurance to the hospital so that the hospital bills directly.

STAFF. Were those assignments to the hospital by the patients?

Mr. SALE. This was for the hospital part.

Now, the Hektoen Institution, collected some eight or nine or 10,000 of these signatures on SSA form, because that is the way they thought they were going to be billed. So, instead of having them on 1490's, we have them on 1554's in most cases.

In other cases the carrier agreed that if the patient was also entitled to medicaid, a signature was already on file assigning his right to reimbursement, and it was not necessary for us to get it from him.

STAFF. This was assigning reimbursement to the hospital?

Mr. SALE. Or the physician.

STAFF. You had a combined assignment?

Mr. SALE. Combined form; yes.

Now, for the last 6 months or so, we have been getting, the admissions department at the hospital, in addition to having the patient sign many other documents, he signs a 1490 assignment for us.

STAFF. And you explain to the patient that this obligates him in the amounts of $400, $500, $600 or $800?

Mr. SALE. No; this is not part of the procedure.

Dr. COLLINS. Our patients only understand two things: "this is my hospital and these are my doctors." They do not know the names of anybody and "I am sick and I want you fellows to treat me. This is my hospital."

That is the universal community attitude, and they do not want to see it phased out, either.

Mr. SALE. We are not arguing that.

Dr. COLLINS. I am just commenting.

Mr. SALE. There is no explanation. When I go into Evanston Hospital, for example, they do not explain anything. I just sign their assignment form covering what insurance I have. It is a teaching hospital.

STAFF. They will bill the service patients, not the private patients. There is a bill for service patients——

Mr. SALE. I beg your pardon. I was in Evanston Hospital, I had an attending physician, two residents and an intern in addition to several nurses. I was seen several times a day by the interns and residents, and while I was very ill, while I was in ICU, I was seen several time a day by the attending.

But, when I started getting well, I was seen daily by his intern and resident and not by my attending. They would phone him and say, "Mr. Sale wants more sleeping pills or something, is it okay," or "can he have a pass to go home for Christmas?"

Then he came in and discharged me.

But he billed me for every day that I was there. This was a teaching hospital, just as much as Cook County is.

Dr. BOUER. I would like to say that I recently commented on a case for an insurance company involving a malpractice action against the physician in a hospital in Illinois, not in Chicago, that has a residency program where one of the most damaging aspects of the action concerned the fact that the physician turned over the surgery on a private patient to the resident because he felt it was necessary to give the resident responsibility and to make the residency attractive. I am not suggesting that this is defensible or indefensible; I am simply telling you that when you are put to sleep in your private hospital, in a hospital that has residents and interns, unless you bring around an observer, you have no guarantee of who did the operation or whether the physician in question stayed in the room.

Mr. SALE. This is a matter of great concern to the AMA and all professional groups, where are we going to get——

Dr. BOUER. It has to do with the concept of both surgery and morals as well as general medicine.

Dr. COLLINS. On admission to St. Francis Hospital, a private hospital in Evanston of some size, 700 beds now, on admission, a patient fills out or has filled out an admission note of financial responsibility and resources, whether they have Blue Shield, Blue Cross, or whether they have private resources to pay for whatever bills are going to accrue. Half the time, from direct experience, the responsible physician in medicine did not necessarily see the patient day after day after day, yet billed for the services that were rendered by the medical staff, the residents in medicine, during a period of 3 months stay.

This is a practice that is common.

STAFF. Yes; we notice that. Apparently in Cook County, G.A.O. found visits for 2 or 3 days of the week and then——

Mr. SALE. Documentation of visits.

STAFF. And billings for every day in the week.

Presumably that stems from your policy which you say Dr. Safian—you say you instituted that policy at Cook County of billing for every day as a result of what you had done at Bellevue following your discussions with Dr. Safian?

Mr. SALE. Yes. This was not only done at Bellevue, but all the teaching hospitals in New York. Dr. Safian insisted on establishing the same procedures at each hospital, whereas in Chicago, Blue Shield has dealt with teaching hospitals individually.

STAFF. It is a strange position for Dr. Safian to take. He has had some rather strong feelings about this.

Mr. SALE. I know, and I have a documentation on his change-of-heart.

STAFF. We do not know whether the change of heart occurred before or after.

Mr. SALE. He was told this is what you are to do.

Dr. COLLINS. No doubt he is facing a manpower crisis in the field of health care.

STAFF. Mr. Sale, we did go to the insurance companies on this question of whether or not they were reimbursing for the services of the teaching physicians, and in our staff report on pages 72 and 73, I thought that we documented it, that basically, they did not. They rarely got bills for this, and they would pay only for the services actually performed by physicians, and when they found that the only bills being submitted to patients were to those with insurance they refused to pay them.

Mr. SALE. But, of course, one of the purposes of medicare and medicaid——

STAFF. You are looking at the green book, but I am looking at the blue book.

Mr. SALE. This is the report of the General Accounting Office with respect to insurance companies and county hospital, the ones that paid, the ones that did not. It is my understanding that it is the purpose of the medicare-medicaid legislation to do away wth the concept of the charity patient. There are no longer charity patients. Everyone is either insured by medicare or medicaid or private insurance, or they are able to pay themselves, theoretically.

There are no longer charity patients. Now, this is in the record, too. Just before we——

STAFF. You mean because of the advent of the medicare and medicaid program.

Dr. COLLINS. No; other insurance, as well.

STAFF. This was to do away with charity patient concepts.

Mr. SALE. But there are still a lot of them around.

Medicaid has a lot of gaps in it; medicare has a lot of gaps in it.

Dr. BAKER. But there are not as many as there used to be.

STAFF. But the cost of charity has gone up.

Mr. SALE. There are a lot of patients at Cook County who do not qualify for medicaid and do not have insurance. Well, with the concurrence of our governing commission, we will begin billing them directly for medical services, as the hospital is doing for hospital services. Now, we have not done any billing since the roof fell in last April, when medicare payments were suspended. We felt we must first clarify our eligibility for medicare payments.

STAFF. Dr. Menguy, who is a member of the Associated Physicians of Cook County Hospital, is here. Dr. Menguy is one of those physicians who is concerned about billing for services which he said he had not provided, but which were billed in his name, during two periods as an attending physician. While he is sitting down, I want to say, we do not want to prolong the discussion unnecessarily.

I understood, Dr. Baker, that you had an additional statement you wanted to make for the record?

Dr. BAKER. No; I think Dr. Collins had.

Dr. COLLINS. I think in this context in this executive session, we have indeed covered the points I would have made in the hearings. So, if, in part, these do become a matter of record there, then it is entirely acceptable.

STAFF. I think it will be part of the record.

Dr. COLLINS. There might be something to add after we hear Dr. Menguy.

Mr. SALE. I would like to make just one expansion of Dr. Baker's statement. That is that although we went along with the Social Security's insistence that we agree to repay so-called overpayments, we feel very strongly that it was not correct for them to change the rules in the middle of the game.

STAFF. I can understand your feeling that way. We feel just as strongly here at the staff level that the ruling they published over there the regulations they published, were not supported by the statutes.

Mr. SALE. The initial SSA guidelines just quoted the regulations.

STAFF. Well, we have a very strong feeling that the reimbursement of teaching physicians is not authorized by the statute. Our concern stops at that point. If Congress wants to authorize it, then that is fine. But our attitude is that on the basis of the study that we had made and the work that we had done is that the payment of supervisory physicians was not reimbursible under the terms of the statute, and they never should have done it in the first place.

Mr. SALE. But the Federal regulations which become law——

STAFF. The Federal Regulations do not become law. The Federal Regulations, presumably fill in gaps in the law. In that context, the people in the Department, after having worked with a committee, made up solely of physicians, published a regulation which, in large measure, complied with the desires of that committee which in large part consisted of teachers of medicine.

We say that in looking at the program in 1969 and 1970, the regulations that they published over there in a host of areas, of which this is just one, ended up paying a whole lot more for services than the statute authorized—looking to the terms of the statute. They felt that they were filling in a gap, and we suggest that they were not filling in a gap here, that they were going beyond the law here.

Mr. SALE. But their proposed regulations were published, I believe, in January of 1967 and not promulgated until August. With all due respect, I should think the Honorable Congressmen and Senators would have had time to say, "No, do not do that."

STAFF. We began saying no to their regulations back in early 1966.

Mr. SALE. But here people such as myself are stuck with the job of carrying these regulations out and trying to get guidance from them. In the absence of guidance, drawing up our own principles and procedures and saying, "Is this okay?" And they said "yes." Now we are penalized very heavily retroactively.

STAFF. I think on this documentation, you could not document even under regulations.

Mr. SALE. There was no requirement for documentation, no mention of it—until the new guidelines of April, 1969.

Dr. BOUER. I have one point I want to make and it is a very crucial one to us.

I came here representing a staff that was, in essence, the granddaddy

of the Associated Physicians. Unfortunately, the term "fraud," was used liberally in the Congressional Record and in the newspapers. Although I am aware that you people did not put it in, that was put in by newspaper people, physicians, and others. Five-hundred physician's morals and character and honesty were impugned by failure to have this strongly denied in print.

On behalf of the staff of Cook County Hospital, I would like to say that we resented the accusation of fraud, and we——

Staff. Abuse, I think those reports said, "fraud and abuse."

Do you also deny abuse?

Dr. Bouer. I am aware of that. Nevertheless, fraud is a very strong word, as you legal gentlemen know. Nobody, our County Commissioners or no one else spoke up and said it was not so. And entering into negotiations with the Social Security Administration and so on, the settlement was arrived at, made and will be undoubtedly, is already beginning to be executed. Yet this nasty word kind of remains in the record, with nobody having spoke up and said it was not so.

Staff. Doctor, I think at this point the reason you were asked in is in connection with the staff report, which deals with much broader problems and with many, many hospitals, not just Cook County, on supervisory physicians' reimbursement.

Obviously, the staff had recommendations in that area, and there are concerns. The House has already taken some steps for tightening up on payments to teaching physicians.

Do you have something to add to that?

Staff. I assume that you wanted to make that statement for the record.

Let me ask you this: do we have any further questions here that we want to explore?

Dr. Collins had something.

Dr. Collins. I defer until after Dr. Menguy to present this statement.

Staff. Dr. Menguy, do you want to go ahead and give your statement?

STATEMENT OF DR. RENE MENGUY, CHAIRMAN, DEPARTMENT OF SURGERY, UNIVERSITY OF CHICAGO CLINICS, CHICAGO, ILL.

Dr. Menguy. I was asked to testify here concerning my experiences in Cook County in a corporation known as the Associated Physicians of Cook County Hospital. I have also been asked to comment on the matter of the current attitude of the Federal Government and the SSA toward reimbursement of teaching hospitals for services rendered to patients eligible for medicare or similar benefits.

First of all, a word about myself. I am a member of the faculty of the University of Chicago School of Medicine and head of its department of surgery, a position which I have held since July of 1965. As a member of the University of Chicago School of Medicine, I practice surgery under a so-called full-time system, which is to say that all of the fees for services which I render to patients are collected by the university and become part of the university budget. My compensation consists of an annual salary, which my wife qualifies as being somewhat meager.

Three years ago in 1967, and before the incorporation of the group called the Associated Physicians of Cook County Hospital, I entered in the following agreement with Dr. Robert Freeark, who was at that time chief of surgery of Cook County Hospital. We agreed to exchange residents in training for a 3-month period so that at all times, one of the residents of the University of Chicago training program would spend 3 months at Cook County Hospital, and one of their residents would reciprocate.

At the same time, it was agreed that I and two other members of my department participate in teaching activities at the Cook County Hospital.

Now, initially, no attention was paid to any financial aspects of any work that we might do at Cook County Hospital, since all of the patients in that institution were covered by county welfare and traditionally, teaching at Cook County Hospital had been done by physicians in the community on a purely voluntary basis.

Now, when the Associated Physicians of Cook County Hospital was organized for the purpose, among others, of collecting medicare fees, I asked Dr. Freeark by letter to assure me that I and those of my colleagues who were teaching at Cook County Hospital would be disengaged from any financial responsibility vis-a-vis any patients with whom we might come into contact in the course of our teaching duties.

By return mail Dr. Freeark informed me of his agreement with this request.

Now, since I had gone to the trouble of arriving at this preliminary agreement and what I felt was on a very important point, I was a little surprised to be told in January of this year that medicare patients treated at Cook County Hospital had been billed in my name. I was all the more surprised that in all the time I was at Cook County Hospital on an attending basis, I had participated in only one surgical operation, and that was certainly not on a medicare patient.

This was administratively and legally a little awkward for me, because I was bound by contractual agreements with the University of Chicago not to engage in the practice of surgery on a fee-for-service basis outside of my parent institution.

Well, having said this and having cleared the air on my own involvement with the whole matter of Cook County Hospital and the Associated Physicians, I would like to make a few comments, comments mainly on the matter of principle.

I think it must be realized that Cook County has functioned, after the advent of medicare, according to traditions which existed long before this country or medicare came into being. That tradition is that students of the healing arts may administer to the sick under the tutelage and supervision of older and learned practitioners and, at the same time, learn their art and take care of the sick and the destitute.

It has been my personal observation and my opinion that Cook County Hospital has functioned very well in this regard. It was my opinion that the physicians and the nurses working at Cook County

Hospital have done, over the years, an absolutely superb job despite enormous political problems related primarily to the political machine in the county of Cook.

Now, these problems were not bad enough; they are now compounded by this whole matter of how that teaching institution, namely: Cook County Hospital and others in the country function vis-a-vis SSA regulations in the Federal Government.

So, speaking on a very broad level and outside of this particular problem I think it has to be realized that there is a very serious confidence gap, and a mutual one, I might add—it goes in both directions—that is now building up between the Federal Government and the teaching institutions of medicine in this country.

One gathers the impression that in Washington, both at the staff and the congressional level, one gets the impression that teaching physicians in this country, or physicians in the whole, are a bunch of money-hungry vultures who are just anxious to get their bloody fingers on every buck they can. And we reciprocate by considering politicians as rather cunning individuals who just cannot see the ideals we strive for and are unwilling to put us on the pedestals we deserve to be on.

Now, that kind of nonsense has to stop or we are both going to be in very, very serious trouble.

I will say one other thing: I have been around quite a bit. I am not an American by necessity, but by love. This is my country of adoption, and I have had the opportunity to see medical schools all over the world. It has to be on the record someplace that this country has the very best medical schools and the very best medical teaching institutions in the whole world, and we have got to keep it that way. We cannot allow this situation to slip to a point where our teaching institutions are gradually going to disintegrate.

Now, I have the impression that the medicare and the SSA regulations and rules have been written administratively without attention to broad principles underlying their application—sort of the cart preceding the horse.

Now, there is one absolutely vital, fundamental principle that has to be understood before these regulations are written or rewritten. I think they have to be rewritten. That fundamental principle is the following: it must be recognized that the care provided in our medical teaching institutions, including places like Cook County Hospital, is, at the very least, as good as and often better than—particularly in certain very highly specialized aspects of medicine and surgery—the care provided in private hospitals not attached to medical schools.

Therefore, the compensation provided by the Federal Government to the former should at least equal that provided to the latter.

Now, as the regulations stand, you see, they are perpetuating the old cottage industry type of traditional medical care, the one patient to a physician, not recognizing the fact that because of the tremendous evolution in medical practice, we have to get away from that and have to go into the team approach of medical care that is practiced in our teaching institutions. And unless the Federal Government provides us

the financial support to practice that kind of medicine, our teaching institutions are going to slip backward instead of progressing forward.

That is what I would like to state and I am delighted to answer any questions you have.

STAFF. Let me ask a question right off. Is it your contention that the support of the teaching hospitals should come from the Government through the medicare program?

Dr. MENGUY. Well, at least this is one possibility. Personally I would like to see some form of national health insurance program. I think this would be ideal. But, until we reach that situation, I think many medical schools, many teaching institutions like Cook County Hospital, looked upon medicare as a means of financial support for what they were doing anyway.

You see, they were doing this anyway, but this was a way of getting some support for it, some method of bolstering the often pathetically inadequate support provided by local political agencies.

STAFF. Doctor, that is one of the reasons that the staff concluded that the present medicare statute did not authorize the payment of these services. They were neither—"usual or customary" before the medicare program, nor did they "prevail" before the medicare program came along.

Now, it has been the experience of this committee in connection with tax legislation—we are constantly called on to amend the tax laws to put in favored treatment or incentives for different sorts of endeavors. It has been the experience of this committee that typically you can get a better result for your dollar by using a direct Federal program rather than an indirect program through a tax subsidy.

The medicare role in the teaching setting, we think, is a little bit like the tax incentive that is often written into tax laws—recently, they have begun to be written out of the tax laws—that the Federal Government, if it has a role in the teaching setting, should provide money directly to the teaching institution not indirectly through the medicare program.

We suspect that the fact that medicare pays for supervisory physician services presently is causing insurance companies to begin to pay for them where before, they never did pay for them. That is pushing up the cost of health insurance because they are having to pay charges that they were never billed for before. That is contributing to the rise in health care costs and the rise in health care costs is the problem that prompted this committee to begin the investigation of the medicare and the medicaid programs before the evils that we see in the program—cost evils, mind you, not necessarily evils in provision of service—become embedded in the program.

The program is about three and a half years old—almost 4 years old. We have tried to investigate the program earlier. We could not investigate the program earlier because they did not have statistics over there which were suitable for analyzing medicare.

The Department over there is at fault, in our opinion, for keeping their statistics for public relations purposes—to show how many old people they cared for and how many days of service were provided.

It was not the sort of statistics that you could use for basic analysis of the program. Those statistics just began to become available when we initiated the study which resulted in the staff report.

Much of the statistical data came at the specific request of the staff. They did not have it previously in Baltimore. When they began to see what some of the answers to the questions were that we were raising, why, everyone connected with the medicare program, inside and outside of Government, began to think about the program a little bit differently from the way they had thought about it. And, hopefully, out of the whole process, we can get a much better program.

In some respects, medicare is our patient and it is a sick patient. Here we need everybody to be the doctor and help us.

Dr. MENGUY. I think one of the main problems I see in all this is that as a group, we physicians, and particularly those of us who are involved in teaching and research and so on, are fantastically naive politically, fantastically naive. The better we are in our field, the more naive we are, because the less time we have to get involved with this. I do not understand that stuff. I do not. I work an 18-hour day, teaching and doing research and operating. I do not have time to become familiar with that.

So, we get snowed and we fall into programs like this that have happened at Cook County, through no fault of our own. That is why I would certainly agree that it is probably certainly unjustified to talk about abuse and fraud and things like that.

Most of the places where this kind of problem has occurred, the physicians involved have been terribly innocent.

STAFF. We said that in the staff report. We said the physicians, judging from the data we have, were not personally benefiting from this money.

We have an HEW audit agency report which shows that in some cases, a large amount of these collections are going to overhead which would not occur through a direct appropriations process, where needs are justified.

Dr. Ebert said that with respect to the team approach, the best teaching services advertise that substantial responsibility is delegated to interns and residents. "Now, the same teaching service must insist that it is really the visiting physician who has the responsibility."

"It is difficult to make these two arguments sound convincing when they are made simultaneously by the same person."

The point is that what you are talking about is an institutional patient who is a patient of the institution, and the staff's point was that that is an institutional expense; it is not an individual physician's cost. It is as simple as that.

Dr. BOUER. I would like to go off the record for a minute.

STAFF. All right; off the record.

(Discussion off the record.)

STAFF. Let us go back on the record because another Senator needs this room shortly.

Dr. COLLINS. Is it possible that the point that was emphasized, that there are some good guys in this, is it not possible that that portion

that should be underlined might at least be referred to Cook County Hospital, that there are some good guys there?

STAFF. We would have to ask GAO.

Dr. Menguy, let me ask you this question: Does your problem with submission of bills for the services, which you say were not, come about because of the peculiar nature of the contract you entered into with Cook County Hospital?

Dr. MENGUY. I am not sure I understand your question.

STAFF. As I recall, you had entered into a contract with Cook County which would relieve you of any financial responsibility.

Mr. MENGUY. It was not a contract; it was an agreement.

STAFF. But you also have an agreement with the university that you would not bill for services, outside——

Dr. MENGUY. Outside of the university, and that is why I requested Dr. Freeark to relieve me of any financial responsibility for anything I might do at Cook County Hospital.

STAFF. Well, is that agreement that you had with the university the reason why you objected to the submission of bills for services?

Dr. MENGUY. Yes.

STAFF. But you said you had not rendered the services to those patients. You could not recall those patients, either?

Dr. MENGUY. That is right; yes.

STAFF. So, there are two kinds of bills you are contesting—No. 1: You had rendered no services at all; and second, even if you had rendered the services, you could not bill for it because of your agreement with the hospital?

Dr. MENGUY. I was in an illegal situation, vis-a-vis, my parent institution if I practiced surgery outside of it on a pay basis. I can go and operate anywhere in Illinois, but for free.

Dr. BAKER. As Dr. Menguy knows very well, and I am in total agreement with everything he said save this one point, I think he sums up admirably the position of teaching medicine today—the only place in which I would like to enter a mild note of disagreement is that Dr. Menguy, despite his contractual relationship with the university, did sign an assignment when he applied for membership—he signed an application for membership in the association and assignment of his "right, title, and interest in and to professional fees for professional services rendered to patients at the Cook County Hospital in the course of his responsibilities as a member of the attending staff of the hospital."

Dr. MENGUY. Well——

STAFF. He says those professional services were——

Dr. BAKER. I have no notion of what was billed in his name. I am just pointing out that despite his written agreement with Dr. Freeark, which we did not know about, in his assignment he did authorize the association to bill for his services.

STAFF. I do not think he argued that.

Dr. BAKER. I am simply introducing that as an aside.

Mr. SALE. I am just concerned, as I informed Dr. Menguy in my note to him, we have not been keeping track of billings in the names

of individual doctors because there was no purpose to it and there was no way to go back and check with whether we had or not.

As I explained in my letter to him, if he were shown as the attending physician to whom a medicare patient was assigned and there was no other attending physician documented in the record, in accordance with our agreement with Blue Shield, we would bill in the name of the attending physician of record. So, it is quite possible, Dr. Menguy, that there was some billing in your name, although I do not know.

Dr. MENGUY. I had specifically asked Dr. Freeark—well, I can read you that.

Mr. SALE. But I did not know about that. If I had, I or Dr. Baker would have certainly asked that you—you could not be a member of the Associated Physicians and also have the agreement with Dr. Freeark, in effect.

Mr. SALE. They were in contradiction.

Dr. MENGUY. Presumably, the Associated Physicians was constituted for purposes other than collecting money. This was a group of physicians forming the full-time and attending staff of Cook County Hospital. There are other things involved in that, I assumed, then collecting money.

Mr. SALE. Precisely.

Dr. MENGUY. May I read it?

STAFF. Please do.

Dr. MENGUY. This is March 12, 1968, addressed to Dr. Freeark.

DEAR BOB: I am writing to you concerning those members of the University of Chicago faculty who hold positions on the attending staff at Cook County Hospital. According to the statutes of the University of Chicago, we are not eligible for liability coverage for clinical work performed outside of our institution, unless monies accruing from such practice revert back to our institution.

With respect to the work that we are doing at Cook County Hospital, following such a practice would lead to a very difficult accounting problem even if this were acceptable to Cook County authorities.

I think that a far simpler solution would be to have some arrangement whereby

Then the usual polite stuff at the end.

those patients with whom we would be involved would be under the name of some other physician, such as one of the full-time staff members at Cook County Hospital.

Then Dr. Freeark's reply dated March 13:

DEAR RENE: I am agreeable to having patients assigned to a member of the full time staff at Cook County Hospital when they received joint supervision by members of your faculty. To my knowledge, this is consistent with your rules and regulations and would appear to enable your men to serve without compromising their liability coverage.

Then I forgot the whole thing. It was an important point, which I had checked with our dean, you see.

STAFF. Dr. Collins, do you want to make a statement?

Dr. COLLINS. Yes.

Leaving out the specifics here, I must say that there is not anything that I would disagree with that Dr. Menguy has said, and I fully endorse his recommendations and the philosophy that he is presenting

in terms of the medical practice in the teaching setting for your consideration.

What I have to say is probably related to the past, the present and the future, and there are just three comments that I would like to make.

First, I think that most of us who are here truly, either the president of the staff and myself as the secretary of the medical staff and treasurer of the association, in fact, do represent the views of the attending staff the executive staff and the full-time staff. We are members of the executive staff. To this end, in regard to the statement last July that was presented to the committee, the person who did present this was acting as an individual, in many of the statements that were made——

STAFF. You are referring to Dr. Samuel Hoffman's statement?

Dr. COLLINS. Yes, indeed. Many of those statements, and the inferences derived from them we wish to repudiate.

I would only add that our executive staff functions just like we hope the Government does, too, in a democratic manner, that it is by majority voice, and decisions are arrived at.

Secondly, I believe that the 500 physicians on our staff and this is inclusive of the 84 to 100—it varies—full-time paid teachers; they really do represent pretty much the cream of the medical community in the city of Chicago. Many of them come from the various universities and medical schools.

I therefore say that pretty much, they are honorable men. Our position and the support of the executive staff in endorsing the Associated Physicians, we believe, is a righteous one, and we have maintained, I think, a consistent position, both in the association and on the executive staff of the hospital.

I think rightfully, we, in good faith, attempted to adhere to the original requiremeents in the Medicare Act and understood the word "direction" clearly, and I think this is one of the key words regarding the supervision and direction of the attending physician. However, the documentation may not be acceptable. Nevertheless, we have negotiated; we have conformed; we have agreed to the decisions that were reached with SSA, and I think we have demonstrated our good faith in this regard by proceeding with the repayment—we have provided a check in the amount of $300,000.

The third point is a simple one: it has been clearly established that some of the physicians, approximately 84 on the staff, do wear two hats, and I have mentioned that before. Of these, about 40 are involved in the care of medical and surgical patients. One hat represents the functions of teaching and administration, while the second hat represents the functions of attending physicians.

For the first function these men are paid a stipend. Mr. Tierney confirmed this at hearing last year on June 9, 1969. Mr. Tierney had also received a communication from the Cook County Civil Service Commission to this effect.

I would only like to say that with regard to teaching in the large public institutions, today they are truly not charity hospitals. I think that the patients have insurance of various types, some more than 68

percent of our patients now have some kind of insurance—Blue Cross, Blue Shield, welfare, the labor union type of thing. The fact is that the institutions of this type are definitely overburdened by both a scarcity of personnel, a tremendous load of patients and, of course, some degree of inadequate facilities.

I think that it is difficult for most of these physicians to write extensive notes on charts. The fact is that they do provide patient care, and the patients do receive this and benefit. I think it is a paradox that at this time, when all agencies are concerned with health resources and the development of professional and allied personnel, there may be a curtailment, a lack of support in some manner that is possible through the present acts and medicare laws.

So, in conclusion, I should like to suggest a partial solution. I think that teaching and public care hospital needs help, especially in support of professional staff, the need to get more teachers, which is a greater lack than even the physician population; perhaps an amendment to the Medicare Act or some new approach to the regulations should be enacted to provide the reimbursement to the physician in the teaching hospital: if, for direction, perhaps one-half of the fee; for direct supervision, presence, and physical action, three-fourths, and if a personal performance of service is involved, perhaps full reimbursement, or a lump sum to the institution.

STAFF. Did that conclude your statement?

Dr. COLLINS. Yes.

STAFF. We have made a suggestion in the staff report relating to a possible method for providing Federal participation in the expenses of teaching hospitals through the medicare program.

Our contention was that the present statute does not authorize it.

We understand that they do have a regulation in effect under which they are now paying something. But we think that the Congress should study this question. If the Congress concludes that there should be a payment under medicare, the statute should be specifically amended to authorize it and state the terms and conditions under which it will be paid.

Now, I would like to express my appreciation and the appreciation of the committee for your willingness to come back this afternoon and sit with us in this executive proceeding.

Dr. Menguy, I apologize on behalf of the committee for the absence of Senators to hear your statement. The committee was in public session until very nearly noon. They are having a debate in the Chamber on the Cambodian resolution. That work in the Senate has disrupted the planned work of the committee.

With that, I thank all of you gentlemen. Pursuant to the chairman's request, the meeting is adjourned until 10 o'clock on Tuesday of next week.

(Thereupon, at 1 p.m. the hearing was adjourned, to reconvene on Tuesday, June 2, 1970, at 10 a.m.)

MEDICARE AND MEDICAID

TUESDAY, JUNE 2, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:15 a.m., in room 2221, New Senate Office Building, Senator Abraham A. Ribicoff presiding.

Present: Senators Ribicoff, Williams of Delaware, and Bennett.

Senator RIBICOFF. The committee will be in order.

Our first witness is Dr. Lowell Bellin.

STATEMENT OF LOWELL E. BELLIN, FIRST DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH, NEW YORK, N.Y.; ACCOMPANIED BY DAVID J. LIEBERMAN, M.D., M.P.H., EXECUTIVE DIRECTOR, MEDICAL ASSISTANCE PROGRAM (MEDICAID), LOUIS L. FELDMAN, M.B.A., DIRECTOR, OFFICE OF GROUP PRACTICE DEVELOPMENT, AND MORTON A. FISHER, D.D.S., M.P.H., DEPUTY EXECUTIVE MEDICAL DIRECTOR, MEDICAL ASSISTANCE PROGRAM (MEDICAID), NEW YORK CITY DEPARTMENT OF HEALTH

Dr. BELLIN. Senator Ribicoff, rather than read the testimony I am handing the testimony into the committee, and I would rather speak extemporaneously and emphasize the highlights in the testimony, and answer any questions you may have.

Senator RIBICOFF. That is fine.

Without objection, your entire statement will be made a part of the record.[1]

You may proceed, sir.

Dr. BELLIN. Thank you.

I have with me this morning members of my staff, Dr. David Lieberman, immediately to my left, who is the executive medical director of the medicaid program at the New York City Health Department. He was formerly director of medicaid of the State of Pennsylvania prior to coming to New York about a year ago to replace me, when I was promoted to be first deputy commissioner of the department.

To his left is Mr. Louis L. Feldman, who is director of the office of group practice of the New York City Health Department.

To my immediate right is Dr. Morton A. Fisher, who is deputy executive medical director of the medicaid program and has been for the past year. Prior to that, he was the director of the dental program of the medicaid program.

[1] See p. 526.

Dr. Lieberman is a physician and has his master of public health degree from the Harvard School of Public Health. Dr. Fisher is a dentist and has his master of public health degree from Columbia.

Mr. Feldman has his business administration degree, his master's degree, from New York University.

I speak with a mixed background before this committee having in my own career worked as an internist medical practitioner and as a clinician in the field of cardiology in Massachusetts. Thereafter I was health commissioner in Springfield, Mass., for 4 years, worked subsequently in a voluntary health insurance program in New York City—that is the HIP prepaid plan—as associate medical director for somewhat over a year and then joined the New York City Health Department as the director of medicaid.

My background then is one of clinical medicine and of public health and medicaid administration.

Historically, American public-health professionals have not had much to do with quality of care or of cost control of health-care services. As a matter of fact, there has been a certain aloofness on the part of American public-health officials in the general field of the delivery health care.

As those cognoscenti from the field can testify, it has been the welfare department that has set up health care services for people under public assistance. This ball game changed completely a few years ago with the onset of the medicare program, particularly in New York State, where the New York State Legislature split the administrative responsibility for the medicaid program between the city department of social services, which is the euphemism for the welfare department, and the city department of public health.

Social services was given the responsibility to pay the bills to both institutional and noninstitutional providers of service, and also to determine eligibility—namely the persons who qualified for the medicaid program.

I think you can see immediately that there was nothing particularly new about these responsibilities being passed on to welfare, because, historically, welfare has always carried out such responsibilities of paying for health care services for people on public assistance and also for determining eligibility.

What was revolutionary about the medicaid program in New York State and elsewhere was that the Health Department was granted the responsibility to establish the monetary value of services and to establish and enforce health care standards.

This was something which health departments had never done before. From personal experience, I can testify that while I was health commissioner in Springfield, Mass., although people who were on my staff would go into nursing homes, for example, and check to see if there was too much water in the soup, or that if there was enough space per patient, nobody on my staff, no public health nurse or sanitarian ever picked up a record to determine whether the particular tests that were done on a periodic basis were ever followed up. For example, no nurse ever picked up a chart to see if there was a urinalysis, the regulations required an annual urinalysis; or if the test was performed if the urinalysis contained red blood cells

and to see if there was suitable follow up. In other words, money was paid, but the Government did not assume what we would consider its responsibility.

In New York City, we spend approximately $750 million a year for medicaid. Approximately $600 million of the $750 million goes to hospitals and nursing homes, and the remainder goes to private practitioners, laboratories, eyeglasses, drugs, appliances, et cetera. This is an enormous sum of money. The significant enrollment that we had in New York City took place about 2 years ago, when we had a medicaid enrollment of approximately 2.5 million people out of a total population of New York City of about 8 million. This represented about 20 percent of the Nation's medicaid enrollment. Subsequently, due to cutbacks by the Congress and the New York State Legislature, the enrollment fell and currently is about 1.8 to 1.9 million.

Senator RIBICOFF. Let me ask you, from your vast experience, do you think that the patients under this system are getting quality health care for the money being spent?

Dr. BELLIN. They are getting some value. They are not getting anywhere near the value of the enormous sums of money we are spending. In other words, if you were to have come to New York to the health department back in 1966 and said, "Here's $750 million for each year, would you have spent the money the way you have had to spend it, given the legal restraints and other conditions of the past 4 years?" I think I can say categorically we would never have spent it this way. I think enormous sums of money have been wasted in the past few years.

Senator RIBICOFF. I think this is what bothers us. If we are committed to a large investment in health, is the form and method of our investment proper? I do not think we should be wedded to any particular system if there is a better system, a better method, where we can get better quality for less cost.

Do you have any thoughts on this?

Dr. BELLIN. Yes. I would say, based upon our experience in New York City, a certain amount of better quality and better cost control can be obtained provided a Government agency is given the authority to impose standards. I want to share with you this morning some of the experiences we have had in New York City which in our view are tragically unique because we cannot seem to get much psychological support elsewhere in the country, with the possible exception of the State of California.

We find ourselves very much alone in the quality and cost-control techniques that we have instituted. I will give you some ideas of some of the things we have done.

For example, when I took over the medicaid program as executive medical director in October of 1967, I began reviewing the printouts and found that there enormous invoices were being submitted to us by some practitioners.

This by itself does not mean that there was hanky-panky going on, but certainly represented something that ought to be looked into. I then decided that we would develop and establish what we call auditing tolerance levels. Any general practitioner, for example, who submitted invoices in excess of $5,000 a month would be subject to

office audit. Any dentist who would submit to us a similar amount of money per month would also be subject to dental office audit.

We established applicable auditing levels for podiatrists and for optometrists. You may wonder how we arrived at the sum of $5,000 a month. It is ironic, but we were immediately accused by some of trying to bring about the egalitarian society because we insisted that any general physician who received $60,000 a year from New York City medicaid ought to be looked into. We arrived at the figure for general practitioners on the following basis. The tolerance level of $5,000 a month would allow an average of 25 patients a day. I have been in practice myself, and I recall that after I saw my 25th patient, physiological fatigue would set in, and I was not doing for the 26th patient what I had done for the first 25. Now, I practiced in New England before I came to New York City. I recognize that the basic metabolic rates of my patients in New York City were higher and, therefore, I doubled the amount of patients I would see in a day and I made it 40. Forty patients a day at the then prevailing medicaid rate adds up to about $5,000 a month. Keep in mind that 40 patients a day are 40 medicaid patients a day. I do not know how many additional nonmedicaid patients they were seeing the same day. We have no statistics on nonmedicaid patients. They could be seeing as many as 80. In view of the fact that we have about 5 to 6 hours a day in the office and you divide, even with the modern math, anywhere from 40 to 80 patients a day into that number, and you come out with an extraordinarily small number of minutes and patients per second.

The argument comes back: we have seen the patients. I have no doubt that the patients are seen, but whether much more is done than seeing the patients is somewhat speculative.

So we established these auditing tolerance levels, and our audit system kicked out any bills being submitted to us on this kind of basis. We sent people in on our staff to private offices. I would say this is the first and thus far remains the only instance in the United States where people on the governmental payroll, professionals, have actually entered private offices of practitioners. This is what we have been doing in New York City.

We do not go in with guns blazing. We go in after an appointment is made at the mutual convenience of the practitioner and of the New York City Health Department. We send in only peers—what we regard as peers. We send in physicians to physicians' offices, podiatrists to podiatrists' offices, and optometrists to optometrists' offices. However, the peer's accountability is to us, because they are on our payroll. Peers look at three major areas. They check the hygienic conditions of offices. Some of the hygienic conditions leave a good deal to be desired, particularly in the poorer areas of the city. They take about 10 to 15 charts at random. We have a list of what are the ingredients of quality we are looking for at least in the records. We would like to have such primitive data as what are the complaints, that the patient was there, that there was some sort of physical examination, that there was either an impression or a diagnosis recorded by the practitioner, that there is a treatment plan, and that the patient is instructed to come back at some ime or no to come back, as the case may be.

Based upon these audits, we have been able to get some impressionistic concept about the quality of care that is being rendered in the medicaid program in our city.

Now, we have been able to do even better than that. We have been able to quantify the quality of care, if you will. I want to share with you some of the statistics that were published last year in the American Journal of Public Health, and additional statistics will be presented later this year at the annual meeting of the American Public Health Association.

I would say, incidentally, that our activity of going into private offices provoked an American Medical Association resolution against us.

Incidentally, the American Medical Association met in New York City last year and regretfully, I think, the five-county medical societies, through their New York City coordinating council, introduced a resolution against our onsite office visitation audits. I would just refer you to it on page 3 of the testimony.

Very briefly, I will read a portion of the resolution:

Whereas, Government-financed health care programs usually place the responsibility for the quality and availability of health services on State and local government officials or other program administrators.

I would say parenthetically that I don't know what other administrators they are talking about, since we are the only program administrators in the country doing this—

And whereas, in many instances, those administrators or officials have considered this to require that audits of the quality of medical services be conducted; and

Whereas, peer review audit systems applicable to ambulatory services rendered in physicians' offices have not been developed; and

Whereas, physicians have demonstrated their impartiality, objectivity, and reliability in auditing and self-policing in their conduct of in-hospital audit committees and can be expected to perform equally well in the field of office audits, once appropriate procedures have been established, therefore be it

Resolved, That the American Medical Association request its counsel to study the legality of onsite audits in physicians' offices, their permissible extent and nature, and how they affect the confidentiality of physicians' records on their patients; and be it further

Resolved, That the American Medical Association express its firm opposition to onsite auditing in physicians' offices in tax-supported programs by representatives of governmental agencies.

Now, we heard through people that the general comment on the floor as this was being discussed was that it is very important that this kind of government auditing be stamped out in New York City lest it spread elsewhere.

An attempt was made by the American Medical Association to see whether there was any legal way of stopping us. I received a copy of a memorandum from their Chicago office. Their legal counsel had concluded that, reprehensible as our activity might be, there was no legal way to stop us from doing onsite audits, and so on, and so forth.

Senator Ribicoff. I am just curious. What do you estimate that these audits have saved the fund?

Dr. Bellin. Well, I would say that our total program during this year—I am referring to the year 1968—we did a cost analysis. For every dollar we put into this program in salary of professionals and

nonprofessional backup, we got back $41. The bulk of our savings, incidentally, was in the field of dentistry, but we recovered significant amounts of money in other areas as well.

Incidentally, I would say a word about dentistry. It is frequently forgotten that the dental program is enormously expensive. In 1968, for example, while we paid for care of physicians provided in private offices about $35 million, our payments to dentists came to $83 million, of which approximately $15 million paid to dental laboratories, leaving $68 million for the dentists, a significant amount of money.

Now, what this actually reflects to anyone who has been in the field of health care administration is really nothing too surprising. Britain underwent a similar experience some years ago when they started their program. It is worth keeping in mind that the poor over the years have received no dental care from eleemosynary sources. Whereas somebody who needed medical or physicians' care could go to an outpatient facility and receive it, we have never had a similar way for providing dental care to the poor, except at dental school facilities. If a poor person was fortunate enough to live in the catchment area of a dental school, he could go to the dental school facility and have his teeth worked on by the students. But over the years, poor people have been gumming it; they have had no teeth or very, very poor teeth.

I can recall hearing in a lecture at the Harvard School of Public Health, when I was a student, that one could recognize a person's socioeconomic class if he just looked at his teeth, like for a horse. You could tell by the number of teeth missing or the condition of the mouth what socioeconomic class he belonged to. We cannot tell that with physician care. But for dental need there was a significant amount of catching up to do. I think this accounts to a great extent for the high cost of medicaid dental expense.

Senator Bennett. Before you leave the dentists, you went by us pretty fast when you were talking about the level at which you were going to make audits. As I remember it, you left the level of $5,000 a month for the dentist as well as the physician.

Dr. Bellin. Yes, sir.

Senator Bennett. Then you quantified the physicians' activity, or you translated it into some minutes per patient. Are the dentist's hourly rates so much higher than the doctor's that he can justify $5,000 a month with a fewer number of patients?

Dr. Bellin. The expense of dental medicaid is based to a significant extent on dentures, partial and complete dentures.

It is worth keeping in mind that dentures may cost anywhere in the medicaid program from $100 to $300. So the dentist may be spending more time and, indeed, does spend more time per patient, but can make an income far, far greater than the physician can in the same time, because the dentists unit payment is higher.

Abuses in any kind of health care program break into three categories. It is worth noting what these three categories are. Category one which grabs the headlines, and which I would say is least important, but nevertheless gets the headlines, is fraud. That is an abuse that everyone can understand. It arises from billing the Government for a service that in actual effect never took place.

The second category of abuse is poor quality. In our view, this is defrauding the public as well, because the taxpayer paid for this and

the proper quality of service was not provided. The abuse which is of far greater importance than fraud is poor quality, unacceptable quality.

The third abuse which is far, far more important, than either fraud or poor quality, is what we call in the jargon overutilization. That is providing a service, a health care expense that is justified neither for preventive reasons nor for therapeutic reasons. Overutilization, service that is unnecessary, is far more important and costly.

We were interested in determining the magnitude of these abuses. At that time, Dr. Fisher, to my right, was head of the dental program, and I asked that he send out letters to about 5,000 or 6,000 patients who had received dental medicaid services and call them back. We have 42 dentists on our payroll, working halftime. I wanted your dentists to examine the patients and review the quality of dental work which the patient had actually received through dental medicaid.

I will share with you the following fact that it is relatively easy to evaluate the quality of dental care, because the dentist always leaves his trail behind in your mouth. We can, through a fairly simple examination, tell you pretty accurately the quality of the dental care you have received.

Our dentists can look at your dentures, your fillings, and can determine whether your mandible is hanging properly or whether you are going to be subject to temporal audinal arthritis: whether your fillings have been shined properly, and so on. That is an esthetic matter, perhaps, but in any case, our dentists can do this.

Technically this is a relatively simple thing to do.

We sent out 6,000 letters, and we got a 20-percent response. This is not bad for this kind of survey, because we were not passing out green stamps to these people, and we were not paying them to come in to see us—they came on a voluntary basis. About 1,200 patients came in. Neither the 6,000 nor the 1,200 who came in represent a random sample. These were patients that we selected because something was not quite right either billing or some other factor. In any case, we wanted to look at these people. The 1,200 people who would come in under such circumstances frequently do so because they have a gripe. I think we should point this out before we inaccurately apply the statistics we are about to give you to the total dental medicaid program.

I will tell you what we found and tell you what I really think the statistics are for the total dental program. Of the 1,200 patients reviewed about 9 percent didn't have the work done at all. We had paid for work, but the work actually was not in the mouth. The fixed bridges were not there, fillings were not there, extractions were not there—the tooth was still there or a third set of teeth had grown in, and from the combined experience of our dentists, we excluded this possibility that 9 percent was fraud.

Another 9 percent, not to be confused with the first 9 percent, represented poor quality of care.

Senator Bennett. What was that?

Dr. Bellin. Another 9 percent represented poor quality of care. When I say poor quality of care, I will tell you that we have become somewhat permissive in what we define as poor quality. We are not talking about A minus or B plus care, we are talking about the kind of care that would have resulted in the deserved flunking out of a

student who tried to pull that type of stuff in the senior year of dental school. This was another 9 percent. Both of these statistics must be viewed in relation to random sampling or statistical validity of the group.

However, there is another problem not related to that. I am referring to dentures. In the denture program, we insist on having 100-percent prior authorization by our staff. Before dentures are put in, the dentist must submit to us X-rays of the patient and our staff of dentists reviews the X-rays and makes a determination as to whether the proposed treatment plan ought to be followed, or modified downward or upward.

In dollars and cents, we modified downward in that year something like $27 million worth of dentures. This would have been in addition to the $83 million we actually spent if we had not had that program. There is no way of determining how many people we prevented or deflected from having unnecessary dentures because of the very fact that there was such a control program in existence. That is speculative.

Overutilization, the difference of opinion between our staff, what we think is necessary, and what the practitioner out there figures is necessary, in our opinion represents about 25 percent of the dental care provided among the patients examined.

I would say that realistically, had we utilized a random sample, our guess on the result would be in the neighborhood not of 9 percent and 9 percent but somewhere between 5 to 10 percent of our dental medicaid services represents clear abuse.

I asked Dr. Fisher at that time because I was not acquainted with the dental literature, I said to him, I don't know what these statistics mean. Maybe this is good. What are comparable statistics going on in Scarsdale or Shaker Heights or West Hartford? What is going on in the typical middle-class or upper-middle-class dental office for purposes of comparability as a kind of control? What goes on in a nonmedicaid dental office?

To my astonishment, Dr. Fisher responded, "I don't know, because no study has ever been performed." This seemed astonishing to us that. just considering that in all these years, the Public Health Service, nor any dental school, nor any Government agency paying for health care has made any study to determine to what extent the graduated student carries out in his private office what he was taught to do.

We have no basis for comparing this. All we can do is tell you what the statistics are. We feel that it is at least 5 to 10 percent.

We were accused of being like cops trying to compile a good arrest record. They said, these are people trying to bring back information and perhaps excessively interested in the consequences.

We, of course, denied this kind of accusation, but said, all right, fine, for our next study, we will not use people on our staff. We will now go into optometry and podiatry. We approached what is left of the Columbia College of Optometry—the New York Optometric Center. We selected a random sample of people who had received optometric services through medicaid. This is another area where it is relatively easy from a technical point of view to evaluate the quality of care. You can always examine the quality of the frame, the quality of the lens, you can through a reexamination, determine whether the appropriate lens was prescribed.

You can review the examination record to determine if the patient should have been referred to an ophthalmologist or some other physician. You can do all of these things.

In this case, these things we were doing could hardly be considered suspect because the peer was the educational institution that has produced most of the optometrists in the New York area. This is the old Columbia School of Optometry, now the Optometric Center. I will share these statistics with you.

We found that 8 percent of the work was acceptable; 20 percent was unacceptable.

Senator RIBICOFF. How much, sir?

Dr. BELLIN. Twenty percent of the optometric work was deemed unacceptable professionally by the school that produced most of the optometrists in that area. The specific breakdown is in the formal testimony.

Senator RIBICOFF. Could you give us offhand the expenditures for optometric services?

Dr. BELLIN. I believe that year it was about $4 million or $5 million. It has gone up since then.

We then decided to do a similar study in podiatry. We approached the college of podiatry of New York, the M. J. Lewis College of Podiatry, which produces most of the podiatrists in New York City. These data have never been revealed before. I will give you these statistics.

Incidentally, I think it is worthwhile, considering this type of information in proper balance, to mention that we had the cooperation of the schools, both in podiatry and optometry. I think this type of cooperation on the part of academic institutions would well be emulated by perhaps some other professional groups.

In a patient sample—this is 500 patients, regarded as a statistically reliable random sample—I refer you to page 18, 61 percent of the work would be considered acceptable.

Senator RIBICOFF. And how much was expended on podiatry services?

Dr. BELLIN. About $6 million, sir.

A particular statistic that was disturbing was the molds. Only 71 percent of the molds in patients over 21 were found to be satisfactory. Among patients under 21, only 58 percent of the molds were considered satisfactory, and these, after all, are on developing feet. We were very disturbed at the unsatisfactory molds that were being placed on children during the age when their feet are undergoing significant development.

Now, once again, we can hardly be accused—these were the schools themselves doing this under our supervision. I would give you another statistic from dentistry which has more statistical validity than the first statistics I gave you. That is on the top of page 18. These are new statistics, never before released.

In the first complete paragraph, of 498 partial dentures that our staff checked—we had the dentures actually checked—only 333, or 66 percent, represented satisfactory craftsmanship.

Of 295 full dentures, a mere 167, or 57 percent, were found to be satisfactory.

Regrettably, I cannot give you any statistics from any other part of the country. Nobody else has done these studies, to our knowledge. If they have done it, they have been quite surreptitious about it and have not released them.

Senator RIBICOFF. When you took this up with the Social Security Administration, what was their reaction to what you have been doing?

Dr. BELLIN. Thus far, we have received a good deal of moral support from Federal and State officials with regard to our auditing program. Most recently—we did not plant the article, it just happened to come out in this morning's Times; it should be in front of you now. You will note that the attorney general of the State commended the New York City Health Department for these programs. It is in the final column. We have received this type of moral support. We would prefer, however, that it be financial support.

It is our view that the great load of abuse and potential saving and potential recovery of funds exists not in the private offices of practitioners, because, as I pointed out, a mere $150 million out of $750 million spent each year is for care provided in private offices. The bulk of funds being spent in medicaid and medicare, too, I would add parenthetically, takes place, of course, in hospitals and nursing homes.

Our experience in New York City shows that, on the average, we have a rate of about $100 to $120 per day, in a semiprivate room. With current union negotiations, it may be up to $140 a day. This being the case, our potential savings are in the hospitals and nursing homes. We have been unable because of limited staffing to move into the hospitals and nursing homes. We have submitted to the Department of Health, Education, and Welfare a proposal which will permit us to move into hospitals and nursing homes and demonstrate that it is possible to do for hospitals and nursing homes what we have already done in private offices.

Senator RIBICOFF. What has been the reaction of the Department of Health, Education, and Welfare to your proposal?

Dr. BELLIN. Thus far, they have been studying it.

Senator RIBICOFF. How long have they been studying it?

Dr. BELLIN. Since late this past year.

Senator RIBICOFF. Since 1969?

Dr. BELLIN. Yes, sir; we have met with them on several occasions and submitted modifications. We hope to have an answer before too long. Basically, it is a hope.

Senator RIBICOFF. But we have these studies and statistics and these limited segments of your expenditures seem to be working out. I am rather surprised that HEW has been so slow in moving to give you this grant, because it would be a pilot program for the entire Nation.

Dr. BELLIN. This is the argument we have advanced. We have stated that, inasmuch as New York City has 20 percent of the Nation's program, we feel this would be an obvious place where a demonstration project for the institutions could be carried out and should be carried out, particularly in view of the fact that the health department there has demonstrated the will to do this kind of activity.

I would say that generally health departments are not particularly enthusiastic about this kind of activity. They have not been trained historically and by activity to be the kind of monitors that are needed. Nevertheless, it is our position that we are not only physicians and

dentists and podiatrists, and so forth, we are public officials and should be concerned about the expenditure of such enormous amounts of tax money.

We are particularly concerned that expenditures of these magnitudes should not be discredited by a small percentage of thieves in practice. I would emphasize that it is only a small percentage, but they have to be controlled.

Senator Williams. To your knowledge, as a result of the work you have done in these various programs, has HEW profited from this to the extent that they have conducted similar studies in other areas to see whether the same practices may exist?

Dr. Bellin. To my knowledge, no, sir; I know of no study being apparently funded by HEW.

Senator Ribicoff. This $2.3 million that you asked for is not just $2.3 million off in the wild blue yonder. From this $2.3 million, the rate of savings you have indicated in personal services would indicate that you would bring back that $2.3 million many, many fold, as well as getting a lot of information that could be useful for the entire Nation.

Dr. Bellin. Yes, sir. We would hasten to state, however, we do not expect to get $41 return for every dollar. Even if we got back $4 or $8 per dollar, and I think that is not an unreasonable thought, this would pay for itself. It would certainly exceed the audit payroll four-fold or eight-fold, and demonstrate what can be done.

Enormous savings are there, there is no question in our minds. I would say that there has been a lot of argument that this type of thing should be done by peer review groups. I think it would be good to review what people who have appeared before you mean by peer group review. We believe peer group review is review by somebody in the identical profession who evaluates the quality of care. We do not think it means that it must be the identical kind of accountability to the identical professional association or identical society. Unless you have accountability to a third party who can assess in a dispassionate and objective fashion, you have a phony peer review.

We have a peer review of what kind of cases we looked into. I think you are aware of the fact that every one of the societies has a grievance committee, to review problems brought primarily by patients who feel aggrieved. I have no doubt that in the majority of these cases, there is no whitewash. I am quite convinced that most of these grievance committees do work sincerely in an attempt to decide what is the truth of a situation and make an appropriate settlement.

However, I think the question that should occur to you is how many cases actually come to the attention of these grievance committees. Since even if practically 100 percent of the cases that come to the medical society comes from patient complaints is that really an appropriate conduit? Only 20 percent of the cases we have investigated came from patients' complaints; 80 percent came from our own casefinding activity.

No professional society has the staff—some say they have—nor the will. But I am willing to concede the will and say they have not the staff to go out and find cases. They have a president who may be president for 1 year or 2 and a secretary. That is the usual staff of a professional society. On the other hand we have hundreds of people

working for us who are going out and looking for trouble, in a sense, reviewing records, reviewing bills, and carrying out a study of governmental controls.

This is, in our opinion, a governmental responsibility that it would be unwise to abdicate to any professional society. I think it would also be unwise to abdicate such responsibility to institutions or to third parties or fiscal intermediaries, have not necessarily covered themselves with glory since the 1965 medicare program.

So in our opinion, one should not rely upon fiscal intermediaries, one should rely upon an appropriate government agency.

Senator RIBICOFF. Is that it, sir?

Dr. BELLIN. Yes, sir.

Senator WILLIAMS. Doctor, based upon your experience, what do you think we would find needed correction in hospitals and nursing homes if such a study were conducted?

Dr. BELLIN. Based upon our experience, sir, and upon my experience in practice, things we have come across just contiguously and the work we have performed in New York City, I would say the major expense in hospitals is prolonged hospitalization that is unnecessary. We find, for example, that for identical diagnoses, two patients within the same hospital who were otherwise similar remain in the hospital for somewhat different lengths of time, depending upon what day of the week they come in.

There would seem to me no basic physiological coordination between the day of the week you get a disease or the length of stay you should be in a hospital. So there are some other things that are taking place that are intervening in the decision as to when the patient is sent home.

If the patient is kept in the hospital until Sunday or Monday, because it is convenient for the family, it means that the Government has paid 2 or 3 days more hospitalization. That adds up to a significant amount of money and moreover fills a bed that should be filled by somebody else.

So our particular kick is length of stay. I think length of stay could be significantly controlled if somebody is watching.

We are aware that under medicare we have hospital utilization committees. We think they have failed. I have yet to see any data satisfactory to me that any hospital utilization committees have succeeded to any significant extent throughout the country.

Senator RIBICOFF. Doctor, the testimony and your statements are very provocative, interesting, and meaningful. Most of us here on the committee feel that there are many lapses and many corrections. I agree with you that it would be unfortunate to have a worthwhile program fail or disintegrate because of methods that are being used. I personally would hope that HEW would make this grant and make it fast.

Frankly, their activities and their conduct of the program has been such that they have not covered themselves with glory, either. If we have somebody who has undertaken a study and is doing a good job, there are many lessons that the Nation could learn as well as governmental agencies on how it could be done. They cannot do it, it is obvious, and they have not been doing it. So I, for one, will write HEW

and ask the staff to get this letter out to them asking for immediate consideration of your grant, because I think it is worthwhile and absolutely necessary.

I wonder, Doctor, if you would mind remaining until after the next witness. The staff may have some questions they would like to ask.

Dr. Bellin. I would be very happy to do so, sir.

Senator Ribicoff. Thank you very much. Your testimony has been very impressive.

How do you account for the great spread in hospital administration?

Dr. Bellin. I think there is a great spread in hospital competency, and I think there is a great spread in courage among hospital administrators.

Senator Ribicoff. I have recently come in contact with University Hospital at 580 First Avenue, and I have been deeply impressed with the way that hospital is run. I think it is probably about as well run a hospital as I have seen all over the country, and I have seen many of them. It has been an eyeopener to me and I have not seen a hospital run like that. Am I correct in my impression that this is a well-run hospital?

Dr. Bellin. An excellent hospital, sir.

Senator Ribicoff. The variance that you see in hospitals amazes me. Thank you.

Senator Bennett. Mr. Chairman, I am sorry, I was called away to the telephone. I have a question.

For the record, Dr. Bellin, there are two or three questions that I think you might answer in order to complete the record.

Most of the discussion on overutilization has been focused on the excessive cost of such overutilization. Could you comment on the effect that overutilization of services might have on the health, particularly, of the elderly person? Can it be harmful to keep an elderly person in a hospital or a nursing home longer than is medically necessary?

Dr. Bellin. It is unsafe to take an elderly patient and keep that patient horizontal when he should be walking about. There are certain medical complications that can take place when a person is lying around in bed. This, of course, would occur to any internist immediately; psychologically, it is not good.

But what I am concerned about is the performance of many kinds of tests. Many diagnostic tests are not absolutely safe. It is unnecessary to subject patients to certain types of tests that can add significantly to the danger unless there is a particular purpose for the test and there can be some kind of therapeutic intervention take place.

Besides diagnosis, of course, there is a question of procedures that are unnecessary. We have found, of course, that sometimes decisions are made by some people, generally speaking, in the minority—they are always in the minority—surgery that is unnecessary, procedures that are unnecessary, medications that are unnecessary. A lot of the problems, of course, depend upon the method of reimbursement for patients in hospitals.

I will share with you some of the problems. Having been in practice myself, I know full well some of the pressures that are made upon a practitioner and I think they have to be considered realistically.

If a physician makes rounds in a hospital, for example—speaking about a nonsurgical physician, let us say an internist—he finds unless

he has eight or nine patients in a hospital, there is no point in his making rounds from a financial point of view, because of the time to get to the hospital, the time to see the patient, the time to get back to his office, he would do better financially by staying in his office. Therefore, there is a certain incentive to maintain a certain patient load in the hospital, if he can. I do not think there is anything invidious about this, but I would say this is a realitsic economic pressure that has to be kept in mind.

So let us say—let us take a magic number of eight—and he has eight patients in the hospital, and a patient says, "Look, it would be a little more convenient for me to go home on Sunday rather than on Thursday evening."

So the physician shrugs his shoulders and says, "Well, all right. Let the patient stay a couple more days."

I think this type of disincentive to discharge we do not find in surgery, because we do not pay for surgery on a per diem basis, we pay on a diagnostic or a procedural basis. That is, whether the patient remains in the hospital for an appendectomy for 3 days or 3 weeks, the surgeon receives the same amount of money, so there is no incentive to keep the patient longer.

I have suggested on a number of occasions and I have urged the people in Blue Cross or Blue Shield with whom I am familiar, please adopt the following idea: Why don't you pay internists on diagnosis? In other words, a diabetic, lumbar pneumonia, things of this type, pay on a diagnostic basis, not on a per diem basis.

I think if such a procedure were developed, we would find a spontaneous appearance, a sudden generation of hospital beds. Thus far, to my knowledge, Blue Shield and Blue Cross have not accepted this idea. I am not being facetious. This is done in surgery and could be done for internists and other physicians basis as well. As long as you pay on a piecework basis, don't be surprised if you have an upcurve of piecework. It works in industry, why would it not work here?

Senator Bennett. Would you not run the risk of having every patient's illness diagnosed one or two grades more serious than it actually is so the family will be delighted to discover that he really does not have cancer, all he has is sore throat?

Dr. Bellin. The ultimate diagnosis that I think he ought to be reimbursed for is the diagnosis on discharge. I do not think any normal physician would diagnose a person who has a sore throat to have cancer to get more money. I think there are certain hooks who might, but this is not the general things. I think we would have in ordinary practice, governmental control not by way of somebody looking over their shoulder to keep most people honest. Most people are honest, anyway. What we are interested in is not really the hard core of thieves who remain thieves no matter what you do.

Based upon our experience in the last few years, I would suggest to you that it is very difficult to control the hard core bandit. The purpose of the control of this program is the rare individual who could fall either way. If they know an occasional person is coming in, doing a sample basis audit, they are going to stay appropriate. The majority of practitoners—this is no whitewash—I think we have the moral capital to make this statement, because we have done this in New York City, and in our experience, the majority of practioners are prudent, wise, decent people who want to do an appropriate job.

We are concerned with this 5 to 10 percent that we have come across that need serious watching and that in our view are milking the program and casting discredit upon it.

Senator Bennett. What do you think of the present efforts of hospital associations to introduce industrial techniques to effect cost control?

Dr. Bellin. I think this is an excellent developement. I think it is long overdue. I would add one thing, however. I would like to see them introduce industrial techniques into health care as well. Thus far, the emphasis has been on things like the dining room and sweeping up, maintenance. I think it is very, very important that industrial engineers get into health care as well.

Thus far, they have been a little bit aloof from this, a little bit worried. There has been a kind of mysticism attached to medical care itself, and industrial engineers have been afraid to move into this area.

I thnk if they do move into this area, they will be able to apply certain kinds of techniques that will save money without in any way rendering imperiling care of patients in hospitals.

Senator Bennett. My next question has to tread a little gently. I come from a small State, most of whose people live in rural areas where they have access to one doctor and that is about it. It is hard for me to see how a kind of governmental audit can operate successfully under those circumstances, so maybe the best thing for our areas is the kind of peer review that the State medical societies are suggesting. Could you comment on limitations or qualifications that should be built into such a program if we find that it is necessary?

Dr. Bellin. Well, let me comment on peer review in the rural areas. I have never understood, for the last 5 years that medicare has been in operation, that we have peer review by physicians on the staff of a particular hospital checking their colleagues in the same hospital. Consider the way this works.

After all, if I am on the staff of hospital X, the doctors whom I am checking and the doctors who are checking me are doctors to whom I have either referred cases or doctors who have referred cases to me. Clearly, if that is not an example of operative conflict of interest, I do not know one.

Therefore, it would seem to me that at the very least, if we are going to have utilization committees on the basis of peer review, why don't we at least get doctors from one staff of a hospital, let us say in another part of the State or an hour away or 2 hours away, to come in and periodically review those records?

In other words, we have to introduce a certain amount of aloofness.

Senator Bennett. Arm's length, I think is the term.

Dr. Bellin. Exactly, and we don't have this arm's length type of thing going on. I think it is extraordinary that for 5 years we have tolerated this type of peer review. I think it is worthwhile pointing out that even the Pope goes to see a parish priest when he confesses. He does not confess to himself. I think this is a kind of peer administrative procedure. We have to separate operations from evaluations.

Senator Bennett. That is all, Mr. Chairman.

Senator Ribicoff. I have no further questions. Thank you very much, Dr. Bellin. Will you please remain.

(Dr. Bellin's prepared statement follows. Hearing continues on p. 538.)

STATEMENT OF DR. LOWELL E. BELLIN, FIRST DEPUTY COMMISSIONER, NEW YORK CITY DEPARTMENT OF HEALTH

Mr. Chairman and distinguished committee members, I am Dr. Lowell E. Bellin, First Deputy Commissioner of the New York City Department of Health. I was formerly the Health Department's Director of Medicaid responsible for the development of the controls on the nature, adequacy and quality of health services paid for by public funds.

Our program has met and overcome severe obstacles from the profession and has survived investigation of State and Federal agencies. To-day monitoring of Title XIX health services is supported by the Department of Health, Education and Welfare. On December 17, 1969 the Department strengthened its procedures to prevent fraudulent abuse of the Medicaid program. These procedures which are intended to help the states strengthen their management of medical assistance programs require the establishment of criteria for identifying possible fraud, and methods for prompt investigation.

THE ROCKY ROAD

For the doctor obsessed with reminscent hankerings for the Zeitgeist of the 1940's, trademarked by the Shadow and Major Bowes' Amateur Hour, by Benny Goodman and bobby sox, and by the roadster and the autogyro, there was bittersweet deja vu in contemplating the deliberations of Medicaid by the American Medical Association during its July, 1969 annual convention in New York City. For a brief time, it was as if the rugged giants of halcyon days had returned to the ideological helm to preside over those denunciatory resolutions of yesteryear denigrating such perilous nonsense as group practice, federal support of medical schools, governmentally subsidized health insurance and mass immunization regardless of the financial status of the patient.

On the basis of a dues paying membership of 219,570 doctors out of a total of 328,366 in the United States, the American Medical Association justifiably claims to be today's most authentic voice of the practicing physician. The AMA leadership is sensible of no disingenousness in insisting that the well being of the patient and the perceived self-interest of the practitioner are ineluctably congruent. A typical AMA convention is a somber affair. Unlike the caricatured conventioneer, doctors away from home and practice indulge in precious little horse play. There may be measured levity as doctors greet old friends and colleagues, and pay touristic homage to the local sights with their families in tow. But that's all. Most practitioners attend annual AMA convenions with their smorgasbord of erudite lectures and technical exhibits to keep up professionally, to absorb knowledge of potential benefit to their patients, and to delve into the gloomy socioeconomic issues inundating health care even in the remotest non-urban hamlet.

The nostalgia for old times was generated at the 1969 convention by the New York City delegation. The Coordinating Council of New York City, speaking for the medical societies of all five counties of the City, was urging passage of a series of resolutions to help stamp out the latest outrage emanating from the New York City Health Department—periodic onsite visitation by doctors, on the governmental payroll, to the offices of private practitioners to audit the quality of care rendered to Medicaid patients. Most assuredly this bureaucratic contagion must not be allowed to spread beyond the metropolitan confines, possibly to be replicated elsewhere in America's hearthland by imitative health departments all too willing to follow the lead of their colleagues in New York City. The resolution was passed. Excerpts provide the flavor:

> Whereas, Government financed health care programs usually place the responsibility for the quality and availability of health services on state and local government officials or other program administrators; and
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> * * * * * * *
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> Whereas, in many instances, those administrators or officials have considered this to require that audits of the quality of medical services be conducted; and
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> * * * * * * *
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> Whereas, Peer review audit systems applicable to ambulatory services rendered in physicians' offices have not been developed; and
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> * * * * * * *

Whereas, Physicians have demonstrated their impartiality, objectivity, and reliability in auditing and self-policing in their conduct of in-hospital audit committees and can be expected to perform equally well in the field of office audits, once appropriate procedures have been established, therefore be it

Resolved, That the American Medical Association request its Counsel to study the legality of on-site audits in physicians' offices, their permissible extent and nature, and how they affect the confidentiality of physicians' records on their patients; and be it further

Resolved, The American Medical Association express its firm opposition to on-site auditing in physicians' offices in tax-supported programs by representatives of governmental agencies.

The real issue here is the fundamental concept of quality control of health care services—under health department impetus and auspices.

MEDICAID CONTROLS

What are some of the things we are trying to measure:

Example: In a private office does the physician routinely record a patient's chief complaint? pertinent case history? physical examination? laboratory tests and x-rays? and plan of therapy? Does the physician follow a proper plan of diagnosis, prevention, and treatment? The patient's chart remains the best clue to the quality of care the patient receives.

Example: In the hospital outpatient department or nursing home, is there an appropriate staffing mix of doctors, nurses, and paraprofessionals? Is there a full-time chief physician of the outpatient department? Or are the interns working without professional supervision?

Example: In the obstetric service, what is the infant mortality rate? The maternal puerperal sepsis rate? Are they higher than normal?

THE PARAMETERS

New York City Medicaid by its enrollment of 1.8 million people and an annual expenditure of about $750 million represents about 20% of the nation's Title XIX costs. Among other services New York City Medicaid provides care by physicians, dentists, pharmacists, optometrist, podiatrists, and chiropractors in private offices, outpatient departments, hospitals and nursing homes to the City's medically indigent, those unable to afford to pay for health care whether or not they are currently on public assistance.

Today about 30% of the City's Medicaid enrollees are not on the welfare rolls. Before the 1968 cutbacks in Medicaid eligibility, about 60% were not. These statistics generally astonish people who conceive of Medicaid as strictly welfare medicine. Despite its growing pains, Medicaid has been described as one of the most significant progressive pieces of American legislation since Social Security. Unlike Medicare, Medicaid finances comprehensive health services to all age groups. Because Medicaid is funded by local and state contributions, as well as by federal, it has been the object of perennial political buffetings.

Medicaid has lacked the relative isolation of Medicare which is administratively ensconced in the Social Security Administration and is 100% financed by government and Insurance Trust Funds. Practitioners participating in Medicaid are reimbursed according to a fee schedule, in contrast to Medicare where payments are related to prevailing private fees. Although the AMA originally opposed Medicare because it paid for services for everyone over age 65 regardless of income, it supported Medicaid because of its means test to define medical indigency. It is ironic that these ideological nuances have been casually ignored by most practicing physicians today. They prefer Medicare to Medicaid because Medicare pays more generously. Also they feel more comfortable with the Medicare mechanism of payment through fiscal intermediaries like Blue Cross and commercial insurance companies. In New York State Medicaid pays doctors in full through social services departments.

The New York City Health Department has had one of the few real programs of quality and cost control of Medicaid financed health services in the country. Such controls are indispensable to protect the patient from biological peril, the taxpayer from piracy, and the typical practitioner from unwarranted smear. Without defensiveness, the Department has perpetrated a number of unconventional things that have disconcerted public health professionals, irritated the leadership of the professional societies, and positively scared the abusers of Medicaid.

THE MONITORS

The auditing staff of the New York City Health Department encompasses: 134 professionals, 60 para-professionals, and 143 clerks. Representative examples of Medicaid auditors on the payroll may be any one of the following:

(a) The staff health care professional who visits the private offices of practitioners to review patients' records at random:

(b) The staff health care professional who re-examines the patient who already has received care;

(c) The staff pharmacist who scrutinizes every prescription for signs of tampering;

(d) The staff health care professional who reviews and suggests modification of treatment plans submitted by dentists, podiatrists, optometrists, and chiropractors before granting prior authorization to render care:

(e) The clerk who reviews invoices for irregularities such as overcharges, double billing, or overutilization:

(f) The para-professional who supports any of the above activities.

Besides using its own staff auditors, the New York City Medicaid administration has entered into agreements with the New York Optometric Center and the M.J. Lewi College of Podiatry to perform audits of quality of care on samples of Medicaid services of optometrists and podiatrists respectively.

In 1968, the New York City auditing program for Medicaid, at an overall cost of $681,475.00, saved a total of $27,398,737.82. In 1969, although there were fewer eligibles, the costs were about the same. Every dollar invested in auditing in 1968 produced a saving of $41.00. We turn over any recovered monies to the City Comptroller. We maintain liaison with his office at all times because our decisions with respect to the amount to be recovered in a specific case ultimately is subject to his approval.

PRO AND CON

The ideological position of the New York City Health Department vis-a-vis governmental auditing of publicly funded health care services was proclaimed in the Department's widely publicized report presented to the American Public Health Association at its annual meeting in Philadelphia in November, 1969:

"If it is obligatory for government to assess the quality of the bridges, and the lunar modules that it purchases with public funds from contracting providers, then it is analogously obligatory for government as consumer representative to assess the quality of health services that it purchases from professional and institutional providers of care. Accountability to the taxpayer as purchaser remains the irreducible issue."

"In short, the New York City Health Department remains unpersuaded by the July, 1969 nationally publicized resolution of the American Medical Association at its annual meeting placing the organization on official record as opposed to governmental auditing of quality care."

Actually Health Department auditing of health care antedates Medicaid. For more than a decade the Department has made periodic inspections of the quality of maternal and infant care services in the City's hospitals. Enforcement of Standards has depended on the fiscal leverage the Department has been able to exert through withholding of federal funds—or in less elegant terms: No quality. No money.

Opponents of governmental auditing of health services have chanted a litany of objections:

They allege that the tools at hand are too imprecise to measure the quality of health care. They call upon health departments to educate rather than penalize errant practitioners. After all, these same practitioners may be the only ones available in the "Ghetto". They insist that if there must be auditing of quality, then professional societies rather than governmental agencies are the only proper mechanisms to scrutinize professional behavior. They claim that established norms of quality do not exist in any abundance anyhow. They emphasize how bizarre it is for physicians, dentists, nurses, and other health professionals on the payrolls of health departments to behave like detectives and check up on the work of their colleagues in actual practice. They tirelessly repeat the refrain that practitioner abuses have been grotesquely exaggerated in the mass media. They reiterate that the majority of practitioners are honest, prudent, and poignantly sensitive to the needs of the public welfare. They go on to bewail the profligate monies spent on auditing by the New York City Health Department, opining that such sums would be more frugally spent for more health care services

instead. They even invoke the issue of civil liberties, admonishing City Health Department officials that governmental auditing violates privacy, imperils confidentiality, and erodes the doctor-patient relationship. In apocalyptic terms they suggest that the City Health Department has accelerated the advent of 1984.

These are all serious allegations. They should not be casually dismissed as debater's ploys cunningly advanced by a mutual protective association of self-seeking practitioners jealous of their prerogatives, obsessed with their income, and indifferent to their social responsibilities. They deserve answers. And the answers in support of auditing are simply overwhelming.

However motivated the altruists of Academe and the professional societies may be, the fiscal and political dynamics implicit in an operating social program like Medicaid are more energizing. Medicaid has already been forced to generate administrative techniques to establish, monitor and enforce the standards of health care. The New York State and by contract the New York City Health department is legislatively designated under Medicaid to stipulate the standards of care. The Health departments must also assess the quality of care to verify that the standards are not a dead letter.

Health departments in the role of consumer advocate and protector must ascertain whether any of the troika of abuses exist: (1) fraud, (2) poor quality of services, or (3) excessive services, or what we call "overutilization." Fraud is fraud. Fraud alone should be subject to penalty.

Poor Quality? Excessive services? Does the practitioner know better? Or is he incompetent? These latter irregularities need education at least until the practitioner has proven by his obstinacy that gentler techniques simply will not work. Only then should the practitioner be suspended from Medicaid—no light penalty, for Medicaid pays for a substantial portion of the practices of 25%–30% of New York City's physicians, and over 60% of New York City's dentists, pharmacists, optometrists, and podiatrists.

It is axiomatic that operations must be isolated from evaluation. The Pope does not confess to himself. He goes to another priest. A peer society cannot by itself dispassionately audit the professional activities of its membership. For optimal results the society must work in partnership with government. Health professionals working for government bear an obligation as public officials to make certain that taxes are not wasted. Although the vast majority of practitioners may be morally above reproach. Government must keep the aberrant minority in check lest chaos result. The economic argument is convincing. For every auditing dollar invested, the New York City Health Department has saved or recovered about $41.00.

Would Health Department auditing endanger privacy and the doctor-patient relationship? Keep in mind that confidential information within or derived from hospital records is customarily seen by many people besides the patient's own physician: (1) consultative physicians, (2) nurses, (3) interns, (4) residents, (5) x-ray technicians, (6) medical record librarians, (7) clerks, (8) Blue Cross or commerical health insurance personnel, etc. Even in the private physician's office, the nurse or secretary has access to the charts. Yet with all these eyes scanning intimate data, it is extraordinarily rare for the canons of privacy to be violated. Similarly health departments have always handled delicate information such as the identities of patients afflicted with venereal disease, tuberculosis, or narcotics addiction. To guard the health and the very lives of the patient and the community is the fundamental purpose of the Health Department's review and analysis of confidential information. The dangers of abuse of medical record information by a health department is remote, for it is the agency that throughout its history has routinely processed hypersensitive data without adverse consequences to privacy, confidentiality or doctor-patient relationships. It is worth recalling that the psychiatrists who deigned to answer the magazine questionnaire on Barry Goldwater's sanity were private practitioners—not health department staff.

The medical societies profess to acknowledge none but professional peers as their legitimate judges. But what is a peer? The correct definition of a peer has masqueraded too long as just a dispute over semantics. Two years of dialogue between the leadership of the local medical societies and the New York City Health Department has boiled down to the following:

Medical Society.—A peer should have a medical degree. We don't want any Ph.D. types or clerks trying to evaluate the quality of our work.

Health Department.—Agreed.

Medical Society.—A peer should also be a clinical practioner—someone in active practice. We don't want a physician who spends the bulk of his time in a laboratory doing research or teaching to evaluate the quality of work of people in actual practice.

Health Department.—Agreed. We use only physicians who are in active practice at least on a part-time basis. For such a job we also eschew academic types.

Medical Society.—A peer should practice the same specialty as the practitioner he is investigating. We don't want internists to study general practitioners or vice versa.

Health Department.—Agreed.

Medical Society.—A peer should also be a member of the Medical Society.

Health Department.—Agreed.

Medical Society.—A peer should be a physician whom we alone select.

Health Department.—No. We can't agree to this—any more than you would agree to have Health Department people decide who should be next year's officers of the Medical Society. But we'll meet you half way. From now on we'll agree to refer to your review the people we choose to work for us as auditors.

Medical Society (astonished).—You really agree to this?

Health Department.—We're not worried. The objective realities of auditing the quality of care are overwhelming. They will co-opt almost any physician you approve in the direction of Health Department standards.

Medical Society.—A peer is also someone who is not on the governmental payroll at all but who works for the Medical Society.

Health Department.—Absolutely not. Here we can't compromise. We can't abdicate this responsibility to a professional association any more than the Federal Communications Commission can permit NBC or CBS to regulate itself. Auditors of health services must be accountable to the Health Department, just as the Health Department is accountable to the public.

Here until recently the discussion would break off. In February, 1970 the Coordinating Council, representing the 5 county medical societies of New York City, finally satisfied itself after consultation with the legal staff of the American Medical Association that it had no legal grounds to thwart governmental auditing. The leadership then met with officials of the New York City Health Department to develop strategy to promulgate a "hold harmless" state statute. This is a law to protect the Medical Societies from any law suit on the part of an aggrieved Society member who may become infuriated by the Medical Society's cooperation with government in evaluating the quality of the professional work he has performed. With the support of both the Medical Society and public health officials such a statute is expected to pass in the New York State Legislature without difficulty.

The current plan is that the Health Department will carry out the case finding. The Department will look into suspicious situations, assemble evidence, and refer the file to the Grievance Committee of the Medical Society for review and recommendations. In each case the City Health Department will make the ultimate decision about the extent to which it will abide by the Society's recommendations. Even those officials within the New York City Health Department most skeptical about the good faith of professional societies in policing their own members concede that under this system, there should be few attempts by the local Medical Societies to whitewash. With government peering over their shoulder, the Grievance Committees of the societies will be scrupulous about applying principles of ethics and high quality care in their review.

THE INITIATION OF THE PROGRAM

1. The New York City Health Department promulgated an administrative regulation compelling health practitioners participating in Medicaid to take a minimal number of hours of continuing education in certified courses with records of attendance—50 hours per year for MD general practitioners and 25 hours per year for dentists, optometrists, and podiatrists. In other words, the Department insisted that the professionals of the learned professions keep on learning, even after they get their licenses to practice. A glorious renaissance of postgraduate education burst forth in New York City thereafter, culminating only when the local dental societies collaborated to bring injunctive proceedings against officials to scuttle the program.

2. The New York City Health Department, with the assistance of technical advisory committees of the professionals stipulated specific standards of care as

a prerequisite for Medicaid payment. Among other examples, the Department laid out staffing patterns in outpatient departments, defined the ingredients of an optometric eye examination, rejected certain medications as non-therapeutic and therefore nonreimbursable, and established time norms for certain health services. In short, the Department began to spell out precisely what it would and would not pay for.

3. The New York City Health Department monitored the quality of Medicaid health care. The Department actually examined the dental care that patients had received from private dentists under Medicaid. Similarly the Department referred samples of patients who had received optometric services to the Optometric Center of New York, and patients who had received podiatric services to the M. J. Lewi College of Podiatry. At these academic institutions the quality of health services was assessed in accordance with Departmental standards. For the first time in history a health department was applying numerical measurements to what goes on in private offices.

4. Maintaining a policy of disclosure, Dr. Mary C. McLaughlin, Commissioner of Health, periodically released to the Senate Finance Committee, to the New York State Joint Legislative Committee on the Problems of Public Health, Medicare, Medicaid and Compulsory Health and Hospital Insurance, and to the public, data generated by these evaluative studies. The City Health Department acquired few new fans among the practitioners for this frankness.

5. The New York City Health Department launched an unprecedented program of onsite visits to the private offices of practitioners to appraise the quality of ambulatory care. What cheekiness was this? It was this last outrage that provoked the AMA denunciation.

TRADITIONAL TECHNIQUES

"Quality Control"—a conventional concept in American industry—is now beginning to slide off the tongues of physicians, hospital administrators, legislators, and public health officials alike, who have become less and less selfconscious about applying the term to the abstraction called health service. If a steel mill can dispassionately check samples of batches of alloys for appropriate mixes of ingredients—and subsequently modify its metallurgic processes in response to these findings—why shouldn't institutions like hospitals, for example, do the same thing, i.e., assess the quality of care they are rendering to their patients?

As a matter of fact to a limited extent, they do—and have done so for decades.

Tissue committees in hospitals review pathological diagnoses of tissue specimens removed by the surgeon during the operation in order to certify that the original surgery was justified—that the microscopic findings of the tissue confirm the surgeon's preoperative diagnosis in a reasonable percentage of the cases. Clinicopathological conferences routinely held at most good hospitals critically analyze the quality of diagnostic and therapeutic procedures that failed to save the patient. Samples of medical charts are periodically pulled from the files and are subject to the scrutiny of one's staff colleagues at many hospitals today in the United States. Moreover, every County Medical Society has some type of organizational mechanism to which aggrieved patients or insurance carriers can refer complaints against allegedly errant physicians for investigative review.

Well, what's wrong with these traditional mechanisms to protect the public from the small percentage of unscrupulous or incompetent practitioners? The answer is simple. As recent headlines on Medicare and Medicaid testify, the methods just have not been effective enough.

OPTIONS OTHER THAN GOVERNMENTAL QUALITY CONTROL

Then why not assign the task of measuring and maintaining quality to commercial health insurance companies? Why call in government? Here the answer is simpler. Despite eloquent pieties at corporate officers' annual banquets, insurance companies really shudder at the thought of entering this technical and political thicket. They have always perceived themselves principally in the role of a conduit for payments. Historically, they have abided by an aloof policy of "hands off" the provider of services. In the absence of outright fraud or flagrant overutilization, they have classified all licensed practitioners as eligible for the insurance payment. The private companies can never be accused of any morbid preoccupation with the subtleties of measuring, muh less enforcing, quality standards of the health care even though financed by enormous sums of their clients' money.

Over the years Blue Cross has done a somewhat better job in quality and cost

control. But, even here Blue Cross is regarded by the cognoscente as fairly lenient in items such as permissible hospital admissions and length of hospital stay, both of which devour tremendous amounts of treasure. Federal officials confess disillusionment with either the will or the ability of Blue Cross to control abuse or maintain quality in the Medicare program. In Medicare Blue Cross generally acts as fiscal intermediary on behalf of government between patient and practitioner.

Why these attitudes on the part of insurance companies and Blue Cross? Is it because of the technical complexities of quality control? These are formidible but certainly not beyond human intellectual potential. In truth the issue is primarily political. The insurance companies and Blue Cross are simply not at all eager to escalate an adversary relationship with hospitals and practitioners.

Why not consumerism? Shouldn't community participation in hospitals and neighborhood ambulatory care centers be enough to watch over quality?

Right now the New York City Health Department is helping set up ambulatory care enterprises that are intertwined with vigorous community participation. It is important to mention this to identify the ideological credentials of the Department. The recipients of publicity funded services face disillusionment if they choose to place excessive reliance with respect to quality of health services upon community boards. The most aggresive community board in the country can address itself only to the amenities of health care, rather than to its technical excellence. This is not to denigrate amenities, such as accessibility to health care, comfortable waiting rooms, reasonable office hours, courtesy towards patients, etc. These amenities are indispensable ingredients of high quality health care services. But, to achieve technical excellence such community boards must ultimately depend upon consultative assistance from professionals. It is here that the Health Department is potentially useful.

The only reasonable option is government—not to replace those quality control mechanisms that are in effect—but to butress them.

MYTHOS AND FACTS

The question of the quality and cost of health services that the American people receive has always provoked polemic, apologia, defensiveness, and cant. The New York City Health Department has begun to collect hard data. The Department has concluded that fraud which grabs the headlines is actually the least important abuse in dollars and cents. It is also clear that but a small percentage of practitioner abuse ever comes to the attention of professional societies. Patients have referred only 20% of the total cases that the Health Department has investigated for possible practitioner abuse. Remember that professional societies depend almost exclusively on such patient complaints. Patients are notorious innocents. Ten years ago, 23% of the quality of surgical care and associated services for members of the Teamsters' Union were judged inadequate by Dr. Raymond E. Trussell and his staff. Yet 80% of the people who had received these inadequate services insisted they were satisfied with the quality of the care. Moreover, professional societies lack the staff or resources to do case findings. At best they can review and recommend after the germane evidence has been gathered by an agency like the City Health Department.

But what about money? If real savings are to be realized, the Health Department must look into hospitals and nursing homes, where $600 million out of the $750 million Medicaid dollars are spent each year in New York City alone. Medicaid physicians in private offices received only $35 million dollars, or just 5% of the total City Medicaid expenditure. But this is not the entire story. Physicians, and only physicians, generally make the decisions (1) when the patient enters the hospital, (2) what services the patient receives, and (3) when the patient is discharged. There are financial consequences to each of these decisions.

Dentists on the staff of the New York City Health Department assessed the quality of Medicaid dental care received by 1,300 patients who came to the Department for examination in response to invitations sent to a total of 6,000. We had selected these 6,000 patients for particular study because their private Medicaid dentists had billed for high volume practices, or had provoked patient complaints, or had submitted questionable invoices. Therefore, these 6,000 cannot be considered a random sample, nor can the 1,300 who submitted themselves to our examination. The statistics derived from this group cannot properly be applied to the total Medicaid dental population, but they are sufficiently disconcerting to clamor for further studies. Of the 1,300 patients examined about 120, or 9%, showed evidence of fraud. In these cases there was no evidence that

the dentist had performed the service for which he had billed the City. In another 120 patients, or 9%, the quality of dental work was execrable. The total of fraud plus poor quality was 18%.

Most recently we studied the quality of Medicaid partial and complete dentures, representing the most costly services in the entire dental program. Of the 498 partial dentures our staff checked, only 333, or 66%, represented satisfactory craftsmanship. Of 295 full dentures, a mere 167, or 57%, were found to be satisfactory. These depressing dental Medicaid data render grotesque the legal action of the local dental societies to block the Health Department's program of compulsory continuing education for Medicaid practitioners.

Our studies of quality in Medicaid optometry and Medicaid podiatry are no less provocative. This time the evaluating professionals were on the staffs of the Optometric Center of New York and the M. J. Lewi College of Podiatry, both academic institutions independent of the New York City Health Department. These alma maters of most of New York City's optometrists and podiatrists could hardly be accused of maximizing negligible abuses in order to compile an impressive critique. They followed protocols of audit and evaluation approved by the City Health Department.

Of 500 patients who received Medicaid care from private optometrists, only about 80% could be categorized as receiving completely satisfactory care.

In a similar patient sample the podiatric care received by only 61% could be considered acceptable. We have been particularly distressed by our statistics on the quality of podiatric moulds. In patients over 21 only 71% of the moulds were found to be satisfactory. The statistic was worse in patients under 21, where it is obviously important for the growing foot of the child or adolescent to receive proper podiatric care. In patients under 21 only 58% received satisfactory. moulds

Statistical buffs will immediately demand control data. Where are the analogous data on comparable non-Medicaid populations? How do we know that the Medicaid statistics are really so bad? Maybe they are no worse than what the non-Medicaid middle class customarily receives in private offices. We don't know for certain. We have always assumed that the middle class gets better care. The pertinent professional literature is curiously sparse on statistics on the quality of ambulatory care. Perhaps the New York City studies will generate such investigations if only in an attempt to refute them.

Dr. Osler Peterson, while on the faculty of the University of North Carolina School of Public Health, found that 55% of patients were not asked to undress or lie down during a physical examination. His studies of North Carolina physicians during the 1950's have their counterpart, at least partially, in the recent onsite Ghetto office visits under the direction of Dr. Florence Kavaler of the New York City Health Department. In general, Dr. Kavaler found inadequacy of office records and episodic and symptom-oriented care, with little attention paid to screening or prevention. She depicted the typical ghetto general practitioner as having limited access to specialists and hospitals but nevertheless compelled to carry an enormous practice. Interestingly she sprang to the defense of the Ghetto practitioner whom she described as "overworked by his patients, abandoned by his colleagues who prefer delivering health services to the affluent, and patronized, criticized, and misunderstood by Medical Academe, the mass media, and the general public."

The preliminary statistics of Medicaid quality should trouble all but the irredeemably complacent. At the same time there is no need to panic. Upon completion of his formal education today, the average practicing physician, dentist, pharmacist, optometrist, podiatrist, etc. is more conversant in technical knowledge than his counterpart of 40, 30, 20, or oven 10 years ago. Likewise the typical patient gets better technical care today than did his parents, or grandparents, albeit often with fewer such amenities as house calls or rapid accessibility to services. But there obviously remains plenty of potential to apply all this superior education of the practitioner. One may argue that rather than the quality of the individual practitioner, it is the delivery system of health services, or the number, kind, or distribution of practitioners that deserves primary attention. But programs of quality control address themselves to these matters as well.

It is the unusual practitioner who relishes a colleague's looking over his shoulder to judge the quality of his professional work. The practitioner is even less enthusiastic about such evaluation when the assessment likely to emerge may at times turn out to be downright unflattering. It is whimsical to expect otherwise. Contrary to the view of simplistic social critics this self protectiveness does not merely reflect the practitioner's covert contempt for the public

good, or his pathological concern for the collective professional ego. Opposition to governmental auditions is not purposely malevolent, but rather quite human and quite natural. Recently, there has been evidence in New York City that health professionals are beginning to abandon their traditional touch-me-not elitism. The professional societies recognize that the masses are no longer in awe and indeed are skeptical about the historic claims and privileges of professionals. On the other hand, professional excellence will never be nurtured by oppressing health professionals. People will not get better care if misled governmental administrators pandering to leveling elements in the population, gleefully give health professionals their comeuppance, and remain content to stop there with no follow up constructive program.

Our evaluative experience in Medicaid has convinced us that most practitioners remain dedicated to their patients' well being. Typical health professionals who care for the medically indigent work extraordinarily long hours often at physical peril to themselves in the Ghetto areas. To characterize as typical those despicable practitioners who mercilessly milk publicly funded programs is terribly unfair. More important perhaps, an exclusive and voyeuristic preoccupation with villainy diverty energies from realistic methods to improve health care programs. It is not mawkish to affirm that to the extent there exists a professional coterie in this country obsessed with considerations of excellence and practical compassion, a major portion of it can be identified in the offices and the institutions of practitioners who minister to the needs of the ill and infirm. Quality control of health services will expand size and distribution of this coterie and hearten those who would be disposed to cast their professional lot with it.

PATIENT ABUSE OF MEDICAID

The chief areas of potential abuse by patients are as follows:

(1) The Medicaid enrollee may illegally transfer his Medicaid identification card to a non-Medicaid enrollee for use in a practitioner's office;

(2) The Medicaid enrollee may obtain duplicate professional services from separate practitioners, e.g. more than one pair of glasses from different optometrists, or more than one set of false teeth from different dentists; and

(3) The Medicaid enrollee may overutilize services from a specific provider.

Without the means to identify such patients, it is impossible to be precise about the magnitude of such abuse. Within one year we expect to have the computer capability to identify all Medicaid services provided to any individual patient.

But, in comparison to the abuse emanating from providers of care, we estimate the dollar cost of patient abuse to be relatively negligible.

INFORMAL HEARINGS

We invite allegedly errant practitioners to the central Medicaid office at the New York City Health Department to discuss apparent irregularities. Practitioners are entitled to bring their attorneys.

The Chairman of these informal hearings has been the Executive Medical Director of Medicaid, either of his two deupties, or the director of the "specific service." The Department of Health or Social Services investigator on the case presents the evidence in support of the alleged irregularities. The Chairman asks the practitioner for an explanation. A peer colleague of the practitioner, from the City Medicaid staff, customarily attends the hearing to provide technical consultation to the Chairman. Minutes are of the entire proceeding.

If the practiitoner's explanation is satisfactory, the Chairman advises him to modify his practice in such a way as to avoid future midunderstandings. If the practitioner's explanation is untenable, the Chairman will suggest any one or a combination of the following:

(1) Recovery of monies.

(2) Financial penalty.

(3) Temporary or permanent elimination of the practitioner as a provider of services from the Medicaid program.

(4) Referral of the practitioner to a formal hearing within the City Health Department.

(5) Referral of the practitioner to the City Commissioner of Investigation.

(6) Referral of the practitioner to the District Attorney.

(7) Referral of the practitioner to the State Board of Professional Licensure.

The following cases are representative of recent informal hearings:

(1) An internist with a high skilled background in nuclear medicine was performing an inordinately large number of liver and brain scans on his own Medicaid patients as well as those referred to him for this purpose by other physicians. We told him that Medicaid could no longer reimburse him for such expensive diagnostic procedures on patients whom in effect he was referring to himself. Henceforth, Medicaid would make payment only for regular patient referrals. The physician acknowledged the reasonableness of this decision.

(2) A general practitioner was almost routinely injecting intramuscular iron into patients afflicted with iron deficiency anemia. We reminded him that less expensive oral iron is as therapeutically effective, assuming neither a peculiar patient contraindication nor a malabsorption problem. The practitioner pledged to alter his prescription habit.

(3) A general practitioner was seeing the majority of his Medicaid patients on house calls rather than in his private office. We declared that we preferred he use his valuable professional time dealing directly with patients, rather than sitting behind the wheel of his car on the way to an apartment house. Most assuredly Medicaid could no longer pay $8 for a house call when a $5 office visit would suffice without risk to the patient. This physician had been making house calls for such non-emergent diagnoses as "hypertension", "anxiety neurosis", "birth control", or "insomnia'. The physician agreed to make his house calls more selectively in the future.

(4) A group of podiatrists routinely x-rayed the right and the left foot of almost 100 percent of their patients. In our estimate this represented 60 percent overutilization of x-rays. We recommended the following: (1) return of 60 percent of the x-ray monies paid or due the podiatrists since the onset of their Medicaid practice; or (2) acceptance by the podiatrists of a penalty of 3-months of total income confiscation by the City. On the advice of their attorney, the three podiatrists accepted the first recommendation, turning back to the City excess monies they had billed Medicaid during their total of 7-months of practice.

(5) A pharmacist "kited' and "shorted" a significant percentage of prescriptions. "Kiting" refers to the pharmacist's forging upward the number of pills originally prescribed by the physician, charging Medicaid for the increased amount but providing the patient with the originally prescribed quantity. "Shorting" refers to the pharmacist's providing a lesser quantity of prescribed medication to the patient but charging Medicaid for the originally prescribed amount. The pharmacist was dropped from further professional participation in Medicaid.

FORMAL HEARINGS

Should the practitioner reject the recommendations of the informal hearing or refuse to participate in the informal hearing altogether, then he may exercise his legal right to proceed directly to a formal hearing before a Health Department hearing officer designated by the City Health Commissioner.

The formal hearing employs the adversary technique of the American courts together with the usual rules of evidence and cross examination. The hearing officer ultimately makes his ruling and recommendations to the Health Commissioner.

If the defendant is dissatisfied with the decision of the formal hearing, he may proceed under Article 78 of the Civil Practice Law. Under this article the complainant has the right to petition the State Supreme Court to review and reverse the decision of the hearing officer on the grounds that such decision was either contrary to law, arbitrary or capricious, or that the punishment imposed was too severe for the offense charged. Either party may appeal the decision to a higher court.

The following are representative of cases that have come to formal hearing:

1. The work of a group of dentists who had billed the City for more than $500,000 in less than a year was of inexcusably poor quality and showed significant evidence of fraud.

2. A group of podiatrists had seriously overutilized x-rays, had performed inadequate follow up, and had excessively prescribed orthopedic shoes. On advice of their attorney, these podiatrists chose to circumvent the informal hearing and proceed directly to the formal hearing.

INFORMAL VS. FORMAL HEARINGS

We prefer informal hearings. They consume less staff time than formal hearings. Due to a shortage in legal staff, the City Health Department has

been obliged to call upon the services of attorneys from the City Legal Department for the formal hearings. Nevertheless, the mechanism of the formal hearing has to be made available, as an option, or errant practitioner could validly charge that the informal hearing is a kangaroo court as the Health Department sits as judge and plaintiff. The Health Department as a matter of policy refuses to authorize payment to accused practitioners while a case is under litigation.

LEGAL LANDMARKS

Besides our own Health Services Administration and Health Department attorneys, the staff of the City Department of Investigations and the District Attorney prosecutes our cases. Both of these latter offices concentrate their energies exclusively on fraud. They prefer that the City Health Department deal with the abuse of overutilization where health care professional judgement is indispensable.

The rulings of three recent cases in 1969 involving the New York City Health Department as respondent are legal landmarks, with respect to Health Department authority and responsibility, in monitoring Medicaid financed care.

In the Bernstein v. Department of Health of the City of New York, June 2, 1969, the State Supreme Court for New York County, Special Term, Part I, Justice McCafferey ruled that the City Health Department had the authority: (1) to establish a Medicaid fee for chiropractors lower than the State's maximal reimbursable Medicaid fee, and (2) to add administrative controls more stringent than those imposed by the State, to wit, the requirement of progress reports to determine whether the proposed number of chiropractic visits is necessary.

In the matter of Fisher v. New York City Department of Health, May 27, 1969, Supreme Court for New York County, Special Term, Part I, Justice Gomez ruled that the City Health Department had the authority to hold a hearing to determine the validity of charges that the petitioner, a private dentist, had submitted fraudulent invoices for Medicaid dental services to the New York City Department of Social Services.

In Ross et al v. City Department of Health, July 7, 1969, Supreme Court for New York County, Special Term, Part I, Justice Hellman ruled that the City Health Department had the authority to suspend or eliminate podiatrists from the Medicaid program for inadequate quality. The court stated:

"Despite petitioners' arguments to the contrary, this Court believes that the recent decision in Matter of Fisher (New York Law Journal, May 27, 1969, Page 2, Gomez, J.) furnishes compelling authority for dismissal of the petition and for upholding respondents' rights to act in the manner challenged. The fact that in Fisher it was claimed that the petitioners' acts were fraudulent while, here, it is asserted, only, that the care provided was of unacceptable quality, unprofessional and often unnecessary, constitutes a distinction without a difference. Recipients of the treatment can be as harmed as much in one case as in the other and respondents' obligations to regulate the quality of care afforded recipients do not vary depending upon the characterization of the wrong allegedly done."

In the last sentence Justice Hellman clearly spells out the regulatory responsibilities of the city health department with respect to quality of care rendered by private practitioners. Such judicial mandates offer a firm basis for increased aggressiveness and provide an irresistible impetus to other public health agencies in the nation to start or expand auditing programs.

THE NEED FOR COST AND UTILIZATION CONTROLS

The control of medical care costs and use is one of the most critical social, political, financial, and medical issues in the United States.

Cost for personal health care in the United States more than tripled in the 12 years from 1957 to 1969, from $15 billion to over $50 billion.

Costs are expected to triple again in the next decade from the present $50 billion plus to $150 billion in 1980, or an annual growth rate of 8%.

Government financing of health care will increase from about one-third of the present $50 billion plus costs to nearly one-half of the 1980 estimate of $150 billion. This is almost a five-fold increase in government expenditures.

The President submitted to the Congress in September 1969 a proposal calling for an additional $136 billion in Medicare payroll taxes over the next 25 years. This increase does not consider costs for any expansion of Medicare coverage to additional beneficiaries or benefits.

QUALIFICATIONS OF THE NEW YORK CITY HEALTH DEPARTMENT TO DEVELOP A COST AND UTILIZATION CONTROL SYSTEM

The New York City Health Department has established and now conducts one of the largest, most active, and most effective Medicaid cost and utilization programs in the Nation. The Department has clearly established its ability to develop and apply control procedures that substantially reduce costs and improve the amount and quality of medical services provided to Medicaid patients.

The Department now seeks to develop more precise and routinely applicable methods to control the costs and use of inpatient services provided by hospitals and nursing homes, which account for the greatest proportion of health care costs. The New York City Medicaid program provides a natural environment for utilizing such control procedures. New York City spent $750 million in 1968 on Medicaid from Federal, State, and City funds, 80% of which was paid to hospitals and nursing homes.

PROPOSED APPROACH TO DEVELOP A COST AND UTILIZATION CONTROL SYSTEM

Any successful cost and utilization control system for hospitals and nursing homes must be based upon standards or norms of use and cost, against which individual reimbursement requests are rapidly processed by computers to indicate deviation from the standards or norms. Deviations per se do not indicate improper care or incorrect charges, but pin-points the cases and the providers requiring attention.

Despite the logic of the approach, no system has yet been developed to routinely control cost and use of health services in large-scale medical payment programs for hospitals and nursing homes. The New York City Health Department proposes to undertake a pilot program to develop such a system, using these four basic steps.

1. Medical care standards or norms for major medical diagnoses will be established and used to evaluate the appropriateness and quality of medical care provided.

Panels of practicing physicians and other health care providers will develop the standards or norms.

This step will be assisted by substantial work that has already been carried out by a number of medical researchers across the country, but which has not yet been routinely applied to cost and utilization control programs in major health services payment programs.

The standards or norms will be concerned with length of stay, laboratory and other supportive services consistent with the diagnosis, complications affecting the length of stay, criteria for discharges, etc.

2. Abstracts of inpatient medical records will be prepared and reported by hospitals and nursing homes.

A limited number of municipal, private not-for-profit, and proprietary hospitals, plus nursing homes, will be used in the proposed pilot project.

Only the cooperating hospitals and nursing homes in the pilot project will be paid for the cost of abstracting records. If the cost and use control system is effective and later expanded to all hospitals and nursing homes, abstracting of medical records would become a component of cost for care provided Medicaid patients.

3. Trends and consistent deviations from established standards or norms will be investigated.

Computer processing will permit the review of all payments request for the selected diagnoses, and bring to attention those institutions deviating most frequently and substantially from the standards or norms.

Field audit teams will be used to visit hospitals and nursing homes, to work with and support their utilization review committees, medical staffs, and administrative personnel, and to accomplish cost and use reductions.

This proposal has been submitted to the Department of Health, Education and Welfare. We hope that one or a combination of H.E.W. units, such as the Health Services and Mental Health Administration, The Social Security Administration, and The Social and Rehabilitation Services, will approve the proposal and provide the finances. The implications of a successful program to contain costs in hospitals and nursing homes has nationwide implications.

Since the onset of Medicaid, we have found ourselves alone among City Health Departments in the country with respect to our program of quality and cost control of private practitioners.

We now want to push into quality and cost control of hospitals and nursing homes—the habitat of the most serious illnesses and the most costly. From experience we have learned to be skeptical about the will or the ability of nongovernmental fiscal intermediaries to invade this technical and political thicket.

Senator RIBICOFF. Mr. John A. DeCell, president, Medicenters of America, Inc.

STATEMENT OF JOHN A. DeCELL, PRESIDENT, MEDICENTERS OF AMERICA, INC.; ACCOMPANIED BY E. A. HERRON, VICE PRESIDENT, PROFESSIONAL RELATIONS

Mr. DECELL. Good morning, Mr. Chairman, members, and staff of the committee.

My name is John A. DeCell. I am president of Medicenters of America, Inc., and I am from Memphis, Tenn. With me this morning is Mr. E. A. Herron, our vice president for professional relations.

Mr. Chairman, we have submitted a statement to you and request that it be included in the record of your sessions here. However, I will not, with your approval, touch on every point included in the statement this morning.

Senator RIBICOFF. That is fine. Without objection, the entire statement will go in the record.[1]

Senator BENNETT. Mr. Chairman, I would like to ask one question for clarification. In your second paragraph, you state that there are 51 medicenters with 7,100 beds. Are they all part of Medicenters of America, Inc., and under the same control?

Mr. DECELL. This is one paragraph I was going to touch on, Senator, with your permission. I will proceed with this.

Thus far in your deliberations, you have heard or will hear presentations from regulatory agencies, health insurers, and the American Hospital Association representing hospitals. I understand you will be hearing from the American Nursing Home Association, representing nursing homes. I think that you will also hear from the National Council of Health Care Services, representing chains of nursing homes.

We have asked for this opportunity to visit with you this morning representing the specific view of a provider of short-term, hospital-related, extended care facilities as opposed to acute hospital care or custodial nursing home care.

Senator, as you have touched on, there are today 51 medicenters open or under construction, with 7,100 beds, in some 24 States.

There are an additional 48 medicenters with approximately 6,900 beds in some stage of development.

Senator BENNETT. Are these franchised or are they owned by the medicenters?

Mr. DECELL. Some of these units are totally or partially owned by our company, some are owned and operated by community not-for-profit hospitals, and some are owned by investor groups.

Senator BENNETT. But since you apparently own the name, you must have some kind of franchise arrangement with them.

Mr. DECELL. We have a licensing arrangement. All of these medicenters are operated under established policies and procedures, and

[1] See p. 554.

routinely supervised. With one exception, all are physically connected to, or in immediate proximity to, general acute hospitals.

Also, the company operates two medicenters in conjunction with medical schools—teaching institutions. We own no hospitals; we own no nursing homes.

Does this answer adequately your question?

Senator BENNETT. Yes.

Mr. DECELL. We note with pleasure your staff's effort to reestablish the concept of extended care as intended by Congress in enacting medicare. I have been assured, Mr. Chairman, and members, that we need not dwell on the differentiation between custodial nursing homes versus the hospital-related extended care, and, therefore, we will not take your time to do so.

I think we would be remiss, though, not to summarize the case for extended care facilities in three basic parts. According to the Public Health Service, in 1969, it cost $44,000 per bed to create a general acute hospital bed. The average project cost for Hill-Burton extended care facilities was $18,000 per bed. That is 41 percent of the cost of hospital construction.

In 1968, hospitals required almost three staff employees per patient. Extended care facilities can be operated at from 0.8 to 1 staff per patient, or about one-third of the requirement of the acute level of care.

Senator WILLIAMS. Is your company public?

Mr. DECELL. Our company is publicly owned. That is correct.

The third justification, if you will, for extended care facilities results in the operating cost savings. In 1968 hospitals averaged $61 per day charge. Extended care facilities should operate at 40 to 60 percent of the hospital cost.

We are not going to dwell, unless you wish to pursue the point, gentlemen, on problems. We have reviewed presentations already made to you and there have been others whose rhetoric exceeds ours and they have already touched on problems. Our purpose in asking for this opportunity is to bring to you recommendations. It is impossible to proceed with these, though, without putting the recommendations in the context of the problems which we feel exist.

First, in our opinion, the Social Security Administration has administered the extended care program, the ECF program, as a nursing home program. They have failed to establish guidelines and incentives for the hospital-related short-term ECF to function in fact as an alternative to hospitalization.

Gentlemen, the point that we wish to mention very quickly to you is that we are encountering around the country hospitals, not-for-profit hospitals, who are closing down extended care units and converting them into acute care beds at acute care cost levels.

It is ironic that just the Saturday before last in our hometown of Memphis, the largest not-for-profit hospital announced that they were closing their extended care unit. As we work in the various States around the country, we find that the maze of paperwork and the lack of incentives by the Social Security Administration is in fact encouraging hospitals to get out of the provision of extended care.

Senator RIBICOFF. What is the difference in paperwork between an extended care facility and acute hospital care?

Mr. DeCell. There is quite a bit. I will specifically try to answer.

First of all, a patient admitted to a general hospital can receive his entire institutional care in the hospital. Transfer to an ECF is permitted after 3 days, but it is not required, nor is it generally encouraged.

If the physician wants to transfer the patient to an extended care facility, he must subject his medical judgment to a determination of eligibility which many times is done by a nonprofessional. This is not generally required in the hospital and is understandably distasteful to the attending physician.

There are duplicate medical records that are currently required upon transfer to an extended care facility. Even after crossing these hurdles, the physician and the patient in the ECF run the risk of subsequent coverage denial. This risk is not incurred if the patient remained in the hospital.

In short, any coverage that is available in the extended care facility is also available in the acute hospital, but at acute hospital cost.

The situation in our judgment is far from hopeless and, in fact, the timing of your deliberations is such that certain changes and redirections now can achieve the original intent of Congress in establishing the concept of extended care.

As I said, we did not ask for the opportunity just to point out problems. We would like to proceed with our recommendations as far as making extended care facilities a viable part of the health care spectrum, be they, Senator, owned by the private company or be they owned by the voluntary not-for-profit hospital or an investor group.

We endorse your staff's finding or suggestion that the Social Security Administration should rigidly enforce provisions of participation. We also concur with their findings regarding recognition of a "distinct part" of facilities, provided that this apply to hospitals and nursing homes equally.

Incidentally, the matter of distinguishing between extended care and custodial nursing home care, in our judgment, could be facilitated by the enactment of the various States of a separate licensure classification for extended care facilities. Our company has developed model legislation, and we are in the process of developing standards, specifically for extended care facilities, and shall attempt to have this introduced in various States. We feel or would recommend that the States should be encouraged to establish the ECF licensure classification. This would certainly lend itself to setting up more rigid standards as your staff has called for.

Perhaps the greatest problem is that of the lack of incentives. We have some definite recommendations to bring to you in this regard: incentives for hospitals, physicians, and patients to utilize extended care facilities in lieu of some part of a hospital stay, and not in addition.

Senator Williams. Are your patients mostly medicare or medicaid?

Mr. DeCell. Senator, most of our patientes. in the system as a whole, are medicare: about 70 percent, I would estimate. Less than 5 percent are medicaid, for reasons that I will touch on in just a moment. The rest are covered by third party insurance, either Blue Cross plans or commercial health insurance, or are responsible for their own bill.

Senator WILLIAMS. When were you first organized?

Mr. DECELL. We commenced operations in June 1965.

Senator WILLIAMS. And primarily based upon the medicare and medicaid programs it became a success?

Mr. DECELL. That is partially correct, Senator Williams. It was based on the need for this type of facility, and medicare provided the bridge for someone to take the first step to provide extended care, because heretofore, it was not covered by commercial health insurance.

Senator WILLIAMS. You were or are a subsidiary of Holiday Inns, as I understand it?

Mr. DECELL. No sir. That is generally misunderstood.

Senator WILLIAMS. What is your affiliation?

Mr. DECELL. The chairman of the board of Holiday Inns, Inc., and the vice chairman of the board, are the reverse with our company—that is, vice chairman and chairman. The two of them own about 43 percent of the stock of the company. We are not a subsidiary. We are an entirely separate company operating in the field of health care.

Senator WILLIAMS. No financial connection between the two corporate structures?

Mr. DECELL. Sometimes we wish there were; but no, sir, there is none.

We began operations to create true extended care facilities, and specifically those related to the short-term recuperative care for patients. We would like to recommend to you that one of the ways to provide incentives to achieve the appropriate utilization of extended care facilities is that SSA be required to determine, based on recommendations from its fiscal intermediaries, average length of acute hospital stays by the major disease classifications and diagnosis, and also determine the upper limit of days of hospital and ECF stays below which 80 percent of the stays would fall.

With your permission, we will use a chart because this is rather difficult to present verbally, and I would like to try to explain what we are suggesting to you.

Many insurance companies have already been conducting these studies. As a matter of fact, we drew on the experience of Massachusetts Blue Cross for this example. If we took the diagnosis of arterioschlerotic heart disease—this for the aged 65 and older, speaking of medicare now—we believe it relatively easy for SSA to determine the average length of stay in a hospital for this diagnosis. There are probably 40 to 50 major disease classifications and diagnoses for which the average length of stay could be determined.

We would suggest to you that a patient be permitted to remain in the hospital with a minimum of paperwork up until the average length of stay. This is not to say that some would not be discharged earlier. But up until this point, there would be no questions or no certification required by the attending physician. If the physician felt the patient needed to remain in the acute hospital beyond this point, then he would be required to justify this to the hospital utilization review committee.

On the other hand, at any time, subject to the physician's judgment, the patient could be transferred to an extended care facility located in immediate proximity to the general acute hospital, and remain there, up to this 80th percentile limit without further justification.

If the physician felt that extended care was needed beyond this 80th percentile point, then he would have to justify this to the utilization review committee.

If, while in the hospital, the utilization review committee disagreed with the physician that additional acute care was required, then benefits should be terminated. If, in the extended care facility, beyond this point—80th percentile—it was determined that no additional institutional care was required, then certainly it should be terminated.

Senator Bennett. How did you arrive at the 80th percentile?

Mr. DeCell. It is a recommendation. It is a recommendation of ours, and which is subject, certainly, to good statistical research. There are probably standard deviations from the average, or the arithmetical mean, which could be established. Perhaps 80 percent is not the best figure. We are merely trying to illustrate an approach here and suggest that this be done by major diagnosis.

Now, I would like to mention something in regard to utilization review. The Social Security Administration has been rather prolific in issuing guidelines for extended care facilities. I have submitted to you a copy of their intermediary letter No. 371, rather pointedly outlining how you determine when a patient ceases to be extended care and becomes custodial. Our research indicates that no such intermediary letters have been issued for hospitals, giving them guidelines to determine levels of care—that is, acute versus extended versus custodial.

Our proposal would streamline physician certification and recertification. We feel that it would encourage appropriate utilization of extended care facilities, and for that matter, shorten the length of stay in institutions when it is not required.

We believe that SSA can easily determine the average length of stay for all diagnoses for medicare patients, and we recommend to you that the coinsurance factor of medicare be brought into play on the day following this average length of stay in the hospital—the average for all patients, not the average by diagnosis.

I think you would probably be told that the average stay is somewhere between 13 and 14 days for medicare patients in the acute hospital. We recommend that, as opposed to the coinsurance factor coming into play on the 61st day, this be moved up then to come into effect on the day following this average stay.

If you do this, you may want to consider reducing the deductible of $52 which you now require, and which as I see by the staff report is scheduled to be increased over the ensuing years.

We are merely saying, then, that you also provide incentives to patients as well as facilities to utilize the less cost facility.

We believe that the requirement for prior hospitalization before admission to an ECF be deleted for certain diagnoses, and particularly where there is an ECF in immediate proximity to the acute hospital so emergency care and adequate services are available. Your staff has alluded to the potential cost savings in their report which deletion of this 3-day prior confinement could achieve. We do not suggest that it be done across the board, but by certain diagnoses which can be determined.

Senator Bennett. Do you recommend that under any circumstances, a person be admitted to extended care without having first gone to an acute hospital?

Mr. DeCell. Only under certain circumstances. Only if an ECF is located in immediate proximity to or physically connected to the hospital, and only for certain diagnoses.

Now, we would like to turn to incentives for physicians. We, too, are treading on thin ice at this point, since we are not professional people. Nevertheless, we concur with the staff's view that we must come up with incentives for physicians to appropriately utilize various health care facilities.

In our research, then, we have come up with a plan which we feel is relatively easy to implement, even though communication may be another problem.

We feel that SSA can determine a relationship, on the basis of statistical information that they have now, for various medical specialities between patient visits in their offices, patients that they see in a hospital, and patients that they see in an extended care facility.

As an example, perhaps we would find that an internist sees 50 percent of his medicare patients annually in his office. Perhaps he sees 20 percent in an extended care facility and 30 percent in a hospital.

Senator Bennett. I notice you do not let him get into the nursing home.

Mr. DeCell. Or in the nursing home as a lesser cost element even than extended care. We rephrase that.

Senator Bennett. So you have four steps, not merely three?

Mr. DeCell. Medicare in part A does not cover custodial nursing home care. Under part B I presume that his fees would be covered. You will forgive our oversight. We probably homed in on that which was covered under part A of medicare, and that does not include nursing homes.

In my example then, if a typical pattern was 50 percent in the office; 20 percent in a hospital, and 30 percent in ECF, then in a given year, if a physician saw 70 percent of his patients in his office, 20 percent in the hospital, and 10 in the extended care facility, there would have been, in all probability, a significant saving to the program. Every time he sees a patient in his office, it costs the program $4, $5, $6. Every time a patient is seen in a hospital—assume one visit per day—the program is incurring a total cost of somewhere around $80. Every time he sees a patient in an extended care facility, the total cost is probably $30 to $35.

What we would recommend to you is that the physician be rewarded financially if he utilized the lower cost types of care, and we can consider nursing home care as a lesser cost alternative even than extended care.

We feel that if, in fact, the physician can save the program money, he should be permitted to share in a part of the savings. We are very mindful that it is not very popular to talk about additional funds going to physicians today, and we have no reason to get involved in that discussion or argument. We are merely saying that some group prepayment plans now in existence do provide a financial incentive to the physician to, first of all, keep patients out of the hospital, and, secondly, to get them out as quickly as possible into less costly facilities. We feel that our proposal, with modifications, is one approach to providing financial incentives to physicians to save money for the overall medicare program.

With regard to incentive reimbursement for providers, we applaud your staff's emphasis on the need to get away from a cost-plus reimbursement, and also their objection to audit overkill and expense.

We have developed and will submit to Social Security Administration within the next several weeks a trial reimbursement program based on incentive reimbursement, the nucleus of which is the prospective budgeting of variable cost with the fiscal intermediary, and providing for an incentive type management fee. If we bring the cost in below the budgeted level, we would share in 20 percent of the savings. If we were under such an incentive and came in with a cost in excess of the budget, we would then be expected to share in 20 percent of the overage.

Under no circumstances, and I wish to emphasize this, even if our trial reimbursement program is discarded and not considered, under no circumstances, in our opinion, should medicare resort to a fixed level of reimbursement for all providers such as has been the practice in the nursing-home industry over the years. This type of reimbursement creates an atmosphere conducive to reducing quality as costs rise in an effort to preserve income over expense. Fixed-level payments certainly provide no incentive to improve the quality of facilities, staffing, or services.

With regard to medicaid, Senator Williams, we are now treating an insignificant number of patients in that program, and that is primarily because the States have not established an extended-care program under medicaid. They have, in our judgment, established nursing-home programs with low-fixed levels of payment. Quite candidly, in most cases, the reimbursement under medicaid just about equals our cost of nursing care, not our total cost.

Senator Williams. In other words, you can make more money on medicaid; therefore, you cater to medicare rather than medicaid, is that correct?

Mr. DeCell. Under the present reimbursement program, it is not a matter of making money; it is a matter of getting cost reimbursed under title 18 and getting less than cost under title 19. We would recommend or suggest that States be required to establish an ECF program in addition to the nursing home and intermediate level program. We feel that the judicious use of extended-care facilities could lessen the cost impact of medicaid.

Senator Williams. Do you think it would be well for the Government to make sure that the payments for medicare did not exceed those of medicaid, or that they be equal so that the medicaid patients would have an equal chance to get in the home as well as medicare?

Mr. DeCell. Senator, we feel that both reimbursements should be based on an incentive reimbursement approach, and they should be equal, yes.

Senator Williams. I am not questioning you about that. We have had complaints that some homes in some areas are catering primarily to medicaid patients because higher rates are approved than for medicare, and in other areas, it would be just the reverse, with the result that in some areas, many medicare patients have a problem of getting service and in other areas, medicaid patients have the problem of getting service, yet they are both Government-related programs.

My question is, Should they be put on a par, or at least should we have some system where a participating institution would have to take a minimum percentage of medicaid patients and have them included as part of the cost?

Mr. DeCell. I would agree, if the reimbursement programs were identical and if the reimbursement programs were in fact incentive reimbursement programs.

Senator Williams. I noticed that in the prospectus issued when you were first organized, you said, "It is anticipated that a significant part of the company's gross income would be derived from payments made under medicare."

Now, how have you progressed under medicare? This report was isued about 1967. In the last 3 years, how have your operations progressed under medicaid? Has it been successful from a market standpoint and earnings standpoint, and so forth?

Mr. DeCell. With regard to the facilities which the company operates, we have been able to operate with medicare. About 70 percent of our patients are beneficiaries of title 18. This is not to say there are not problems. As we have mentioned, we have tried to work very closely with SSA to seek solutions. We have just not found a willingness on their part to innovate or find or come up with solutions.

Senator, pardon the emphasis here. I suspect the greatest problem we have had in the 5 years we have been in business as a corporate entity is the confusion in many minds between nursing-home care and extended care. I think we find ourselves more often preaching the concept of extended care than promoting Medicenters specifically. It is unfortunate that the medical profession has not assumed the responsibility of education—perhaps they will in the future—of physicians as to what is extended care versus nursing-home care.

Senator Bennett. Before you leave that, what have you done to try to educate the physicians? You are a corporation operating for profit. If this were a corporation making a product, you would have a public relations program going because you have your product to sell.

Mr. DeCell. We have spent great effort, not all of it effective, in communicating with the professional community on a national basis. Mr. Herron was with the American Medical Asociation at a meeting last Tuesday to brief them on what we would be recommending to you.

On a local basis, wherever we open a Medicenter, we have a program of information and education for the physician.

In the final analysis, we can do but so much as laymen. I think the best communication comes from peer groups as you were discussing a moment ago. We are constantly seeking better ways to communicate with the professional community.

Senator Bennett. What kind of a program do you have—a mail program? Do you hold seminars? Do you visit them in their offices? What kind of a sales program do you have for these doctors?

Mr. DeCell. Certainly, there is direct mailing. In some cases, we are asked to present programs to the local county medical societies, which we readily accept. We do visit with them in their offices. We do have special lunches or open houses for them in the facilities so they

can see that the emphasis is in fact placed on recuperative care, short term. All of this is but one part of the total program, and one that we will have to continue to learn better ways of doing.

Senator BENNETT. But you still have not been very successful?

Mr. DECELL. I would say we have been reasonably successful with the physician. But, quite frankly, until he has incentives or until we can remove the disincentives—as long as it is easier for him to utilize the acute hospital as opposed to transfer to an ECF, he will continue to do so, with the result that we build more acute hospitals and we staff more acute hospitals. I would again say that we have been reasonably successful, but we still have a long way to go in regard to effective communication with the physicians.

Senator BENNETT. You leave the impression that the physician will not make the move unless there is money in it for him, unless he has some kind of a financial incentive. Do you not think he has enough interest in his patients, if the situation is properly presented, that he will react rationally?

Mr. DECELL. He does, certainly. He has an interest in his patients, and we think the typical physician is mindful of the cost, but under the present program there is no cost to the patient to remain in the hospital up until the 61st day. The coinsurance factor does not come into play until the 61st day. So it really is not a case of saving the patient money. It is saving the program money, but that is a once-removed third party.

May I state again, please: first of all, we need to find ways to remove disincentive, to make it easy to utilize the less expensive facility.

Secondly, then, I believe we need to establish financial incentives. There is precedent for this. We did not come up with this thought. Your staff has already suggested it. As I mentioned earlier, the group prepayment plans that have reduced hospital utilization, that have reduced system cost of health care, have found it necessary to provide financial incentives to physicians in order to achieve this result. We concur in that.

Did I answer the question?

Senator BENNETT. Yes, sir.

Mr. DECELL. I would like to close my remarks with one comment. We know that you are mindful of publicly owned companies operating in the health care field and we felt that perhaps you would have questions. We are very happy to talk with you about our motives. I can sum up our motives very quickly.

Our purpose is to maximize quality and availability of health care the United States to achieve this purpose. We must realize profits that will attract lenders and investors. The amount of the profit is determined in the competitive financial market. We would submit to you that our effort is but one example of what we term responsible private enterprise in the health care field.

There are three things, then, that we can achieve, we and other responsible private enterprise. First of all, we can bring about an infusion of capital into the creation of economical, functional health care facilities. Just recently, we concluded about a $19 million first mortgage bond offering to institutional investors. This obviously reduces the demand on local, State, and Federal funding and financial assistance.

Secondly, we feel that responsible private enterprise can design, build, and equip these facilities much less expensively. I mentioned to you in 1969, the average hospital cost $44,000 per bed, and the Hill-Burton involved ECF cost $18,000 per bed. Our medicenters, which generally meet or exceed Hill-Burton standards, today are averaging $8,000 per bed. Our development time is approximately 18 months as compared to 2 to 3 years where Federal funds are involved.

The third and final reason: responsible private enterprise in health care can improve efficiency through the application of good business practices. We feel that we can materially increase the production of employees through typical corporate employee benefits such as profit sharing. Not-for-profit hospitals have been struggling for years to find a way to introduce a form of profit sharing in hospital care. We are able in our operation of extended care facilities to do that. Our average charge per day last year was about $31 versus the $61 per day in the general acute hospital in 1968. We do not yet have the 1969 figures for hospitals.

So our premise is simply this: the profit motive in health care is not inherently good or bad. It is how you use it. This is directly related to the structure of governmental and private health insurance programs. Given proper incentives, well-defined guidelines, and an atmosphere of economic opportunity, we feel that the profit motive can operate side by side with not-for-profit interest as well as regulatory agencies, which will result in delivery of highest quality of care for all people. And that is at the lowest possible cost.

I thank you again for permitting us to visit with you to present our ideas for your consideration. We would welcome the opportunity if it is appropriate to work with your staff as they continue their considerations.

I will be happy to answer any additional questions which you have at this time.

Senator Williams. First, I want to emphasize that—just speaking for myself, but I think for the full committee—that we recognize and respect the right of private ownership and that the profit motive is the essential ingredient that keeps private industry operating. We understand that. At the same time, we want to make sure the Government gets value received.

Now, under your setup, as I understand it, whether it is a franchise or a licensing fee, you charge a fee of $100 per bed and a minimum of $5,000 for each franchise; is that right?

Mr. DeCell. That is the initial fee, yes.

Senator Williams. Plus $10,000?

Mr. DeCell. No.

Senator Williams. There is no flat $10,000 fee?

Mr. DeCell. No.

Senator Williams. What they pay is the hundred dollars per bed or $5,000, whichever is greater, is that correct?

Mr. DeCell. That is correct.

Senator Williams. Your average center would be about 100 beds; is that right?

Mr. DeCell. I think today they are averaging about 120 beds, but 100 is within reason.

Senator Williams. I have noticed that you have one at least as low as 49 beds, so the very minimum fee that one would pay is $5,000?

Mr. DeCell. The minimum is $5,000, so if it is a 50-bed facility, that is still $100.

Senator Williams. What would be the gross receipts from an average bed per year?

Mr. DeCell. Last year, as I mentioned, we were averaging $31 charge per day per person.

Senator Williams. And your utilization per year would be about how much?

Mr. DeCell. On a 50-bed facility?

Senator Williams. Well, any one.

Mr. DeCell. Is this the one you are referring to?

Senator Williams. No, I am just figuring any one of them. What is your average?

Mr. DeCell. I think the average would be about 70 percent, considering the units that have been open longer than 1 year.

Senator Williams. That would be about 245 days per year that you would be collecting pay for. Is that correct? And how much per day?

Mr. DeCell. $31.

Senator Williams. Now, in addition to this initial fee, do you collect a percentage on the gross revenue?

Mr. DeCell. Yes; 3 percent.

Three percent from room and board, Senator, not from gross revenues. Of the $31, we would estimate $25 to $26 would be room and board. Five or six dollars a day from ancillary charges such as lab, X-ray, pharmacy, physical therapy, and so forth.

Senator Williams. I am just reading from your own report.

At present, the initial fee is $100 per bed or $5,000, whichever is greater, and subsequent royalties are 3 percent of gross revenues received by the licensee for basic room, board, nursing services.

Mr. DeCell. That is right.

Senator Williams. One percent on all other services?

Mr. DeCell. That is right.

Senator Williams. Now, approximately how much will you collect a year on that one bed?

Mr. DeCell. I think for purposes of your illustration, we could use 3 percent of the total revenue. The figure is a little over $200.

Senator Bennett. Two hundred dollars per year per bed? You mean the parent company would collect $200 per year per bed?

Senator Williams. Yes.

Senator Bennett. Rather than the facility.

Mr. DeCell. Something over $200.

Senator Williams. Around $220 per year per bed?

Mr. DeCell. Yes, sir.

Senator Williams. In other words, when the Government goes into this facility to establish the permissible reimbursement, taking into consideration the costs in these facilities which are under your licensing plan, they have this $100 per bed original payment as a part of the cost of the operation.

Mr. DeCell. Excuse me, I think that is capitalized, not treated as a part of the operation.

Senator Williams. I know, but it is ultimately recovered, so it is ultimately to be paid?

Mr. DeCell. Yes.

Senator Williams. And ultimately to be paid out of the services paid for by medicare?

Mr. DeCell. Right.

Senator Williams. And your receipts from gross revenue is around $220 extra cost per bed, which the Government or medicare would be assuming as a result of your supervision; is that correct?

Mr. DeCell. No, sir, I respectfully disagree with you. It is not an additional cost. I think the part we should consider here, Senator Williams, is what would the cost have been if we had not been involved?

Senator Williams. We will get to that in a moment; the extent to which you can reduce costs as a result of your efficiency or whatever it might be. But this $220 per year, which is paid to you, to the parent organization by the small franchised nursing home, is a part of their cost and it must be recovered in the medicare payments; is that not correct?

Mr. DeCell. It is a part of cost for extended care facilities, yes.

Senator Williams. Therefore, it is included as part of the cost, as well as the 1 percent royalties on other types of services?

Mr. DeCell That is correct.

Senator Williams. Now, do you feel that this has resulted in a pyramiding of these costs over a period of time? What services do you render to offset this?

Mr. DeCell. That is a very fair question. I appreciate the opportunity to answer it.

As a matter of fact, for the royalties, the services we are providing are primarily related to the ongoing operation of the facility as opposed to a front-end charge. We conduct a formal training program for administrators of extended care facilities—not nursing homes.

Senator Williams. Does the facility have to buy that service and pay for it, or is it given to them free by the parent organization?

Mr. DeCell. That is the part of what we give for the royalties and fees given to us.

Senator Williams. There is no charge to the facility at all?

Mr. DeCell. No, sir.

A training program for the administrator. There is also an orientation program for the director of nursing. The assistance in establishing and opening the facility, the ongoing consultative services by specialists such as medical records librarians, nurses, or accountants. That is particularly needed today under the present reimbursement provisions of medicare. We have to have one whole department which specializes in understanding and interpreting the regulations.

As a matter of fact, if the facility lost its administrator because of normal turnover in personnel, we have administrators to staff the facility for them so that there is a continuity of management during this period of time.

A part of what we provide is a standby type of service, much like buying an insurance policy against fire. When the facility incurs problems they draw on us most heavily, although we will be in every medicenter at least 10 times each year with one of our representatives, providing various services.

Beginning next month, we will be bringing our company-owned units onto our central computer for patient accounting, and anticipate

that this will be extended to cover our licensed facilities within the next 12 months. So there is a constant emphasis, Senator Williams, in producing services for money paid. I can assure you that our agreements with licensees are arms-length type transactions, and that they themselves want to be assured that they are getting quality. This is particularly true of the not-for-profit hospitals that have licensed medicenters.

Senator WILLIAMS. When your company was first formed, I understand in 1965, it was capitalized for around $1 par, is that correct?

Mr. DECELL. That is correct.

Senator WILLIAMS. And how has it progressed over the years?

Mr. DECELL. Well, we have had relatively successful development. We have not yet achieved our real goals and we will be 5 years old next week, as you remember. The net worth of the company now is $9 million. We will have revenues from the last year of something in excess of $20 million. Our profits for the whole corporate entity are nowhere near what they should be at this point.

It is important for you to understand, though, please, that we are engaged in two or three activities related to health care, each of which must produce its reasonable profit for the assets and equity employed.

Senator WILLIAMS. You anticipated my next question.

Your company owns several service facilities and supply groups for these operations which are under your jurisdiction, do you not? And are medicenters required to utilize the company's services, or can they go out in the competitive field and obtain those services elsewhere?

Mr. DECELL. Thank you. This is extremely important and I must do a good job of answering that question.

First of all, with regard to company-owned medicenters, we have a construction division that builds our company-owned facilities. There is no profit. They go on our books at hard cost.

We have a division of the company that is involved in the furnishing and equipping of health care facilities for company-owned facilities. The furniture and fixtures go on the books at hard cost. There is no profit.

With regard to licensed facilities—we do not own them—the licensee is free to choose any general contractor, he is free to use any supplier of furniture, fixtures, or equipment that he pleases. Those that we sell, we do so by old-fashioned selling, and there is no requirement that they utilize our construction division or our furnishing and equipment division.

Senator WILLIAMS. For any of the services?

Mr. DECELL. Other than that which is provided under our license arrangement and we talked about it a moment ago.

Senator WILLIAMS. What does the license arrangement cover in the way of supplies?

Mr. DECELL. There are no supplies that they must purchase from us. There are no pieces of equipment that they must purchase from us.

Senator WILLIAMS. Well, you did not finish. You talked about your stocks at par value of $1 a share. I notice that the market price was substantially higher than that later. But how is it faring generally?

Mr. DECELL. Terribly. We are interested in your staff comments about the effect of rising stock prices on motives in health care. I

thought perhaps there had been a market answer to that concern recently. But our stock today is about $11 to $12 bid and asked. It was initially issued at $10 a share. There was a 2-for-1 split, which would make it the equivalent of $5 a share. It has been as high, to give the full picture, as $62 a share. I think I can tell you very candidly, and I am not speaking for any other company, that the market value of the stock did not in any way affect our long-term or short-term goals that we wished to accomplish as a corporate entity.

I can also tell you as one member of the company that it was nice when the roller coaster was on top and it has been a little uncomfortable at the bottom, but our goals, corporatewise, remain the same.

Senator WILLIAMS. It is about $10 today, you say?

Mr. DECELL. I think so.

Senator WILLIAMS. About $12 a share?

Mr. DECELL. About $12 today.

I am sorry, I do not follow you. You are speaking of a par value of $1?

Senator WILLIAMS. That is what I understood you to say, that originally in 1965, you started out at $1 par.

Mr. DECELL. You say $1 par. But we were not publicly owned in 1965. In 1966, we became publicly owned. At that time, it was originally offered at $10 a share.

Senator WILLIAMS. At that time, you went public at $10?

Mr. DECELL. Yes, sir.

Senator WILLIAMS. I understand that. But was $1 the original basis of your cost before you went public?

Mr. DECELL. No, it was a par value, merely assigned to the stock as a par value of $1. I think the book value was something in excess of $1.

Senator WILLIAMS. It was approximately $1.

Mr. DECELL. Book value?

Senator WILLIAMS. Book value, based on this.

Mr. DECELL. I think you will find the book value somewhat in excess of that now. We have assets somewhere in excess of $30 million.

Senator WILLIAMS. That is good.

Senator RIBICOFF. Thank you very much.

Would you please remain, both of you, to follow Dr. Bellin? The staff would have some questions.

Senator WILLIAMS. Just one additional question.

Are any of your franchise holders local physicans in private practice who admit or treat their patients in the medicenter facility?

Mr. DECELL. Yes. I think that in several of the groups, there are physicians who own a part of it, or own stock in the corporation that owns the license. I do not think there is a group consisting of physicians only. I am mindful of why you are asking that. There is not a requirement on our part that before we issue a license, we have to have physician ownership. It matters not to us with regard to the ownership so long as it is a stable group. To our knowledge, we have encountered no problems of conflict of interest. We do not speak to potential problems.

Senator WILLIAMS. I wondered if you saw any problems that could be created as a result of such ownership?

Mr. DeCell. I think it is an area of potential conflict of interest. We were somewhat hesitant, and I think you can understand why, to question the Judicial Council of the American Medical Association when they formally found that it is acceptable for a physician to own a part of a medical-care facility provided that the patient has a free choice of physician while he is there. I think they are probably going to reconsider that. That is an opinion.

Senator Williams. Do you encourage it or discourage it?

Mr. DeCell. We do not feel it is appropriate for us to take a part in the AMA Judicial Council's considerations.

Senator Williams. Well, if you feel or have opinions about the matter, I can quite understand that. Do you think that the fact that the physician may own a part of the facility would help or retard chances of increasing utilization of that facility?

Mr. DeCell. Senator Williams, I will speak on the basis of our experience in the brief——

Senator Williams. Just speak in broad general terms of whether you think that is a good practice?

Mr. DeCell. We do not necessarily presume that a physician owner will over utilize. We assume that there is a potential for conflict of interest, so I think perhaps we have to find better ways of determining when and if, in fact, it occurs.

Senator Williams. If you feel that that is necessary and you have not been doing anything about it, what are your plans for the future? Will you try to correct it or do you think——

Mr. DeCell. We have not found any problem in our program, Senator. That is what I am trying to relate.

Senator Williams. Do you think that conflict of interest would relate only to others but would not apply to you?

Mr. DeCell. I will not be that brazen. I am just saying on the basis of our experience today, it has not.

I will say this to you: The bulk of our interest right now, the thrust of the company, is working directly with community hospitals, either in the establishment of a company-owned facility on their land, such as we have done with Boston University Medical Center and Vanderbilt University in Nashville, or to assist them in creating a hospital-owned medicenter.

Now, when you ask do we intend to do something with regard to physicians, I have to very candidly say it is not a point of consideration now, because the investor-type interest in a license is at its lowest point, and I think primarily as a result of general financial conditions.

Senator Williams. You quickly answered the question, so you must know in general terms the extent to which this condition would exist, where physicians would own an interest and you would be generally aware of it?

Mr. De Cell. Oh, I acknowledge to you that there are medicenters——

Senator Williams. To your knowledge, in your own case.

The reason I ask that is this: The mere fact that we ask this question may be interpreted as casting an unfair reflection, that there may be something wrong with it when, in reality, as you stated, there may be nothing at all wrong with it. So in fairness to all who are involved, since the question has been asked and we have both indicated that we

think there is a potential conflict of interest, would you furnish to the committee a list of the facilities in which there is physician-ownership, the percentage of ownership that they have, and the utilization in those particular facilities where those physicians have been owners as compared with the utilization in those other facilities which do not have physician ownership?

Mr. DeCell. We wll be glad to submit an appropriate statement.

Senator Williams. You will furnish those statistics to the committee, will you? I ask that on the basis that perhaps if you clear it up, we avoid any unfair reflection.

(The following letter was subsequently received by the committee:)

Medicenters of America, Inc.
June 16, 1970.

Committee on Finance, U.S. Senate,
Washington, D.C.

Dear Sirs: When we testified before the Finance Committee on June 2nd, Senator Williams requested that we supply whatever information we could in regard to any correlation between physician ownership and increased occupancy. We have now secured the data for the most recent fiscal period in each Medicenter which has been open one year or longer.

Medicenters of America is responsible for total operation of the limited partnership Medicenters. There was only one open for more than one year in which there is no physician ownership. The average occupancy in this facility was 65 percent. There were two partnerships which do have some physician ownership, and the overall average occupancy for these two facilities was 33 percent.

There were four franchise Medicenters with no physician ownership, and the overall average occupancy for these was 81 percent. For the seven franchises which do have some physician involvement, the overall average was 71 percent.

During the question and answer session following my testimony, I stated that it appeared to us that physician partners were leaning over backward not to utilize the Medicenters so that they could not be accused of a conflict of interest. In our experience this has been generally true, and the physicians which utilize Medicenters most heavily usually do not have any ownership interest in the facility. We do not know whether the above figures indicate a coincidental or a causal relationship between physician ownership and lower occupancy, but they certainly do not indicate that physician ownership causes increased occupancy.

We hope that this information will be helpful to you. We appreciated the opportunity of testifying before the ad hoc committee, and if there is any further information which we can provide, we would be happy to do so.

Sincerely,

John A. DeCell, *President.*

Mr. DeCell. I would like to comment conversely on an experience that we have had. This is by no means reacting to the question, because there is no reason not to discuss it openly.

We are the general partner in partnerships that involve or include among other investors some physicians. As a practical matter we have found that the physicians probably lean over backward not to utilize the facilities for fear that they will either be suspected or questioned about their participation.

Senator Williams. I understand that, and that is the reason I thought we should get these statistics, because it is unfair to leave a semicloud over a group when perhaps the situation is quite to the contrary. So this would just clear up the record.

Mr. DeCell. Senator Williams, you are known for your attention to detail and I thank you for your fairness in questioning me.

Senator Bennett. I have a question now.

You said with respect to this general partnership that these physicians lean over backward not to use the facilities. Do you mean not to overuse or that the physician-partners go somewhere else?

Mr. DeCell. They do not use it.

Senator Bennett. They do not use it at all?

Mr. DeCell. Let's not make an ironclad statement that they never use it. I am saying in our judgment, they lean over backward not to use the facility for fear of criticism.

Senator Bennett. They do not refer patients to it?

Mr. DeCell. They do not refer as many patients to it as other physicians in the same facility.

Senator Bennett. They are careful not to overuse it?

Mr. DeCell. Yes, sir.

Senator Williams. Would that mean they use some other facility or does that mean that the patient who could use the treatment is not getting it because they will not use the facility?

Mr. DeCell. Senator, I think it means they are leaving them in the hospital where no question is asked.

Senator Ribicoff. Thank you very much. We want to thank all of you and you will be available to the staff. We will meet tomorrow at 10 o'clock.

(Mr. DeCell's prepared statement follows. Hearing continues on p. 558.)

Prepared Statement of John A. DeCell, President and a Director, Medicenters of America, Inc.

Mr. Chairman. members and staff of the Committee, my name is John A. DeCell and I am President and a Director of Medicenters of America, Inc. of Memphis, Tennessee. Thus far in your considerations of Medicare and Medicade you have heard presentations from regulatory agencies, health insurers, the American Hospital Association representing the view of acute hospitals, the American Nursing Home Association representing individual nursing homes, and the National Council of Health Care Services representing chains of nursing homes. We have asked for the opportunity to appear before you representing the specific view of a provider of short term, hospital-related, extended care as opposed to acute hospital or long term nursing home care.

Today there are 51 Medicenters with 7,100 beds open or under construction in 24 states. There are an additional 48 Medicenters with approximately 6,900 beds in process. Some of these units are totally or partially owned by our company, some are owned and operated by community not-for-profit hospitals, and some are owned by investor groups. All Medicenters are operated under our standard procedures and are routinely inspected by the company. With one exception, all are physically connected to or in immediate proximity to general acute hospitals. The company also operates two Medicenters in conjunction with medical schools. We own no hospitals and no nursing homes.

We note with pleasure your staff's effort to reestablish the concept of extended care as intended by Congress in enacting Medicare as "post-hospital skilled nursing and rehabilitative care . . . an *alternative*, less costly institutional setting for the provision of medical care;" as opposed to nursing home care. We have been assured by your staff that we need not dwell on the theoretical contributions of extended care facilities since the Committee is already aware of these. We will therefore state the case for extended care facilities in the following summary:

1. According to the Public Health Service, general acute hospital project cost for the 200 to 300 bed units where Hill-Burton grants were involved reached an average of $44,000 per bed in 1969. The average project cost per bed for extended care facilities where Hill-Burton grants were involved was only $18,000 in 1969 . . . 41% of hospital costs.

2. In 1968, general acute hospitals required a staffing ratio of 2.72 staff for every patient and this ratio is increasing.

Extended care facility staffing will range from .8 to 1 staff member per patient.

3. Hospital costs and charges have been increasing at more than 15% each year with the average charge in 1968 amounting to $61.38.

Extended care facility charges range from 40 to 60% of hospital charges.

In our opinion, the Social Security Administration has regretably administered the ECF program as a nursing home program, and has failed to establish guidelines and incentives to permit the short term, hospital-related ECF to in fact function as "an alternative" to acute hospitalization. As a result, community hospitals have been discouraged in their considerations of an ECF unit. We are aware of several hospitals that are converting ECF beds to acute beds because of the additional paperwork and restrictions placed on extended care facilities by SSA.

The situation has been further aggravated by the failure of organized medicine to effectively inform the professional community as to the function of the ECF as opposed to acute hospitals and custodial nursing homes.

Under present regulations, there are disincentives for physicians and patients to utilize extended care facilities. Any patient admitted to a hospital can receive his entire institutional care in the acute facility. The patient pays a deductible of $52 and co-insurance of $13 per day commencing on the 61st day. Transfer to an ECF is permitted after three days in the hospital, but is not required not generally encouraged. Where utilization review functions in hospitals, the consideration usually centers on whether the patient needs institutional care or not, and does not include a determination of the appropriate level of care . . . that is acute, extended or custodial.

The Social Security Administration has prolifically issued utilization review directives for extended care facilities such as Intermediary Letter No. 371, a copy of which I have for you, which establishes procedures for the ECF to determine when a patient's condition ceases to qualify for extended care and becomes custodial care thereby terminating Medicare coverage. This is a reasonable requirement on the ECF. Conversely, our research indicates that *no* Intermediary Letters have ever been issued dealing with hospital utilization, much less letters requiring a determination of level of care and introducing the possibility of loss of benefits.

Under present regulations, the physician wishing to transfer a Medicare beneficiary to an extended care facility must subject his medical judgment to a determination of eligibility which many times is made by a non-professional. This is not required in the hospital and is understandably distasteful to the physician.

Present regulations require certain duplicate medical records such as history, physical examination, hospital discharge summary, physician certification, among others, even though this information is generally available in the hospital records.

Even after clearing these obstacles, the patient, physician, and the ECF run the risk of subsequent coverage denial by the fiscal intermediary—a determination which is not required and a risk not normally incurred if the patient simply remained in the hospital. In short, any coverage available in the ECF is also available in the hospital—at acute hospital costs.

The situation is far from hopeless, and in fact the timing of your deliberations is such that certain changes and redirection now can achieve Congress' original intent in establishing the concept of extended care. We did not ask for the opportunity of meeting with you to dwell on the problems, but to present positive recommendations for your consideration.

STRICT ENFORCEMENT OF ECF STANDARDS

The Social Security Administration should strictly enforce the "conditions of participation" pertaining to extended care facilities as recommended by your staff. We also concur with the staff's comments on recognition of a "distant part" of facilities provided that this apply equally to hospitals and nursing homes.

The matter of distinguishing extended care from nursing home care would be facilitated by the enactment of legislation by the various States establishing a separate licensure classification for extended care facilities. Our company has developed model licensure legislation, and is in the process of developing standards for introduction in State legislatures. I have provided a copy of the legislation for your review. We believe that the States should be encouraged to establish a separate classification for extended care facilities.

ESTABLISH INCENTIVES FOR THE APPROPRIATE USE OF EXTENDED CARE FACILITIES

Incentives must be established for hospitals, physicians, and patients to utilize extended care facilities in lieu of some part of a hospital stay and not in addition to a usual hospital stay. We urge you to consider the following changes:

1. Require that SSA determine, on the basis of its intermediaries' recommendations, average length of acute hospital stays for beneficiaries by disease classification and diagnosis; and also determine the upper limit of days of hospital and ECF stays below which 80 percent of the stays would fall (80th percentile).
2. Delete the present requirement that the physician certify the hospital admission, using instead the physician's usual admission request to the hospital.
3. Delete the requirement for recertification by the physician on the 12th and 18th day.
4. Require SSA to issue guidelines for hospital utilization review committees to use in determining levels of care.
5. Require the physician to submit to the hospital utilization review committee "justification for acute care" if a beneficiary remains in the acute facility beyond the average stay established for that particular diagnosis or classification.
6. Terminate medicare benefits for patients remaining in the hospital beyond the appropriate average length of stay when the patient's condition is such that transfer to an ECF, nursing home, or house is determined to be appropriate by the hospital utilization review committee (assuming of course that an ECF is available in immediate proximity to the hospital and nursing homes are available in the general community).
7. Require that approved hospital stays beyond the average (by diagnosis) be reviewed by the hospital utilization review committee every 7 days.
8. Require that beneficiaries commence payment of the coinsurance amount on the day following the average length of hospital stay for all diagnosis. (Your committee may want to consider reducing the deductible in view of the stepped up payment of coinsurance.)
9. Delete the requirement for physician certification and determination of level of care for beneficiaries transferred to an ECF within the upper limit (80th percentile) of stay established by diagnosis.
10. Require the physician to submit to the ECF utilization review committee "justification for extended care" if a beneficiary remains in the ECF beyond the upper limit of stay (including the days in the acute facility) established for that particular diagnosis.
11. Terminate benefits for patients remaining beyond the upper limit of total institutional stay whose condition is determined to be custodial by the ECF utilization review committee.
12. Require that approved extended care stays in excess of the upper limit of total days be reviewed by the utilization review committee of the ECF every 14 days.
13. Delete the requirement for prior hospitalization for admission to the ECF located in immediate proximity to the hospital for certain diagnosis. Your staff has alluded to the cost savings which this change could effect.
14. Establish a financial incentive program for physicians by determining by medical specialty an annual target relationsip between medicare patient visits in the office, in the acute hospital, and in the ECF; record annually each physician's actual visits to beneficiaries, and financially reward those whose visits are weighted toward the lower cost levels of care progressing from office to ECF to acute hospital.

INCENTIVE REIMBURSEMENT

We applaud your staff's emphasis on the development of equitable incentive reimbursement plans as opposed to cost plus reimbursement, and their objection to audit "overkill". Our company has developed a trial incentive reimbursement program which we will submit to SSA within the next several weeks. I can provide copies for your committee now and also answer detailed questions on the program if you deem it appropriate.

The nucleus of our reimbursement program is a cost-plus-incentive fee approach to the variable operating costs required for all patients. These budgeted costs would be prospectively approved by the fiscal intermediary and a fee determined. The provider would share in 20 percent of the costs which exceeded the

budget and in 20 percent of the savings if actual costs were less than budget. The audit of an independent certified public accounting firm could be the basis for the medicare audit thereby significantly reducing the administrative cost of the program.

Under no circumstances in our opinion, should medicare resort to a fixed level of reimbursement for all providers such as has been the practice in the nursing home industry for many years. This type of payment creates an atmosphere conducive to reducing quality as costs rise in order to protect desired margins of income over expense. Fixed level payments certainly provide no incentive to improve the quality of facilities, staffing, or services.

EXTENSION OF MEDICAID TO COVER EXTENDED CARE FACILITIES

The judicious use of extended care facilities could lessen the cost impact of the medicaid program if structured along the lines which we have suggested for medicare. Unfortunately most if not all States have elected to establish a nursing home program with low, fixed level payments to all providers. The net effect is that those medicaid patients who require only extended care receive the care in acute hospitals and the States reimburse the hospitals at hospital cost levels under the medicare formula. We recommend that the States be required to establish an effective extended care program for medicaid patients in addition to a custodial nursing home program.

USE OF FISCAL INTERMEDIARIES

We note with interest your staff's comments concerning the medicare fiscal intermediaries' performance. Our company has utilized five different Blue Cross plans, three commercial insurance companies, and dealt directly with SSA on two projects. We encountered wide variation between intermediaries, expensive duplication of audit, and a general inability to get consistent answers. We have now changed to one commercial insurance company as our nationwide intermediary, and while we receive no special considerations, we find it much easier to function because of standardization of procedures and policies. We also feel that the program will experience a significant cost savings by our using one intermediary.

THE ROLE OF PRIVATE ENTERPRISE IN HEALTH CARE

The role of publicly owned "chain" operations in the hospital, ECF, and nursing home field has been questioned by your staff, and I shall not try to respond for this rather general grouping, but I will conclude my remarks with a brief discussion of our motives which I submit as an example of responsible private enterprise.

The purpose of our company is to maximize the quality and availability of health care in the United States by providing health related facilities, services and products. To achieve our purpose, we must realize sufficient profits to attract investors and lenders—the amount of profit required is generally set by a competitive financial market place.

Given the possibility to earn profits competitive with other investments, responsible private enterprise can make three major contributions to health care:

1. It can introduce and maintain an infusion of capital into the creation of health care facilities, thereby reducing the demands on local, State and Federal government for funding or financial assistance. Just recently, for example, our company completed the private placement of $18,925,000 mortgage bonds with institutional investors to be used in the development of medicenters.

2. It can design, build, and equip more functional and economical facilities much faster than is now being done. I mentioned earlier that the average cost to build a hospital in 1969 was $44,000 per bed and that ECF construction costs involving Hill-Burton funds averaged $18,000. The cost of our medicenters, which generally meet or exceed Hill-Burton requirements, is approximately $8,000 per bed. Our development time is approximately 18 months as compared to 2 to 3 years where Federal funds are involved.

3. It can improve the efficiency of health care operations through the application of good business practices, and materially increase the motivation and production of employees through typical corporate employee benefits such as profitsharing, thereby lessening the problem of a shortage of competent, well-trained personnel. Our average total charge per patient per day in 1969 was approximately $31 as compared to $61.38 per patient per day hospital charge in 1968.

We submit that medicare and other purchasers of health care should operate on the basis of the prudent buyer concept where concern is centered on the total cost of hospital, ECF, nursing home and outpatient care, individually, and not on the component parts that make up each. It makes little sense to be concerned about the cost of each item so long as the total cost is within acceptable limits. We reject the implication by your staff that activity in various health care markets necessarily means an effort by all companies to inflate prices to the government.

Our premise in this presentation is simply this. The profit motive is not inherently good or bad. It is the use of the profit motive that determines its worthiness, and this is directly controlled by the structure of private and governmental health insurance programs. Given proper incentives, well-defined guidelines, and an atmosphere of economic opportunity, the profit motive can work side by side with the voluntary not-for-profit interests and regulatory agencies, which will result in the delivery of the highest quality of care at the lowest possible cost for all people.

Thank you for allowing me to present our company's views and recommendations for your consideration. We would welcome the opportunity to work with your staff in developing improvements in the medicare and medicaid programs.

STAFF. Dr. Bellin, we have just a few more questions to complete the record.

On the last page of your written statement, you indicated that you were going to move into the area of quality and cost control of hospitals and nursing homes.

STATEMENT OF DR. LOWELL E. BELLIN, RESUMED

Dr. BELLIN. Yes, sir.

STAFF. You indicated that you were skeptical about the will or ability of fiscal intermediaries to enter those areas. What is the basis for that skepticism?

Dr. BELLIN. Well, first of all, I think it is worth while to consider the history of fiscal intermediaries: what is their origin. Blue Cross is a product of the American Hospital Association historically; Blue Shield is a product of the medical societies historically. When we discuss things like arm's-length relationships, one would have some doubt, it seems to me, that one could maintain arm's-length relationships when a creature of an organization is checking the organization itself. To be sure, in Frankenstein, the monster turned upon the creator, but this only happens ordinarily in fiction. It does not happen too often in real life.

I think what we have seen, not only from the historical point of view, but specifically what has happened during the last 5 years of medicare and in those areas of medicaid, in different parts of the country where fiscal intermediaries have been used, we have not seen the most vigorous type of enforcement, to say the least. We find no comparison whatsoever between the vigor with which, for example, our department carries on quality and cost control—Heaven knows, we are very conscious of our own warts and blemishes in this area because of limited staff and limited resources—and the vigor and will and competence in which such quality and cost control activities are being carried out elsewhere. I think generally speaking, when you talk to intermediaries and ask them what are they doing, they trot out certain esoteric cases and they say, you see, in such and such a case, a flagrant abuse, we have cracked down. I think this kind of thing is very useful from a propagandistic point of view. That is not where

the money is lost, on these exotic cases, but rather on the day-to-day kind of cases which require a good deal more vigorous approach than we have seen operate during the last 5 years.

STAFF. You indicated in your testimony data on quality of care and over utilization with respect to noninstitutional services. Do you have any preliminary data indicating similar situations in institutional care? You noted earlier, factors such as hospitalization for the convenience of the physician or the convenience of the patient.

Dr. BELLIN. We do not have these data as yet because we have not gone into this area as yet. We have not had the staff nor have we had the money to do this. Indeed, we are going to move into this within 2 months, whether or not we get the grant to start this, really to indicate what one can do when one puts his foot into this thicket. The only way we are going to do this, frankly, is to sacrifice part of our program that we have carried out in private offices and we are just going to have to reassign our resources to hospitals and nursing homes.

One of the problems that we anticipate is the ability to get into these institutions nationally to do this. But we think that we have a certain degree of persuasiveness in New York City and we hope that we will get the kind of support that the institutions really should offer a governmental agency in this type of activity. We do not have these statistics.

I think this kind of question, and I say this with all due respect, should properly be addressed to the fiscal intermediaries and to the Social Security Administration with respect to medicare. They ought to have the statistics on what the amount of abuse has been. I know a question I have asked is how many facilities, how many nursing homes or hospitals have you suspended or closed down or cast out of the medicare program during the past year and where has this actually taken place? I think this kind of answer would be responsive to that kind of question.

STAFF. You have indicated that you are concerned about excessive lengths of stay. Are you concerned at all about overservicing of patients in hospitals? Have you had any indications of that with respect to hospitals and nursing homes—excessive X-rays and lab tests for instance?

Dr. BELLIN. I am primarily concerned with length of stay. I think that to be sure, on a day-to-day basis, there is a possibility for some overservicing to take place. But I think to a significant extent, you can control this overservicing by limiting the amount of time.

I think the approach by the previous witness mentioned a few moments ago is a very good one. I think they almost looked at the proposal that we submitted to HEW. It is based upon the same concept, that there is an average number of days for each diagnosis. Our proposal to HEW would suggest that the way to go about this would be to carry on a kind of administration by exclusion—that every patient who remained in the hospital, let's say 10 days, for example, for a peptic ulcer, assuming that is the average amount of time for a peptic ulcer, the hospital would be paid without question, but any days beyond that would have to be justified. We know there are four or five specific complications of a peptic ulcer, for example, and you could

justify continued hospitalization. If one of those four or five complications are indeed present, we would have no question about that addition and we would happily pay.

If, however, these four or five complications were not present, we would hold payment from the physician. I think once you withhold payment and once the physician realizes that he is not going to be paid for additional days beyond that which is acceptable, I think you will find a significant diminution in length of stay.

I think that if you speak surreptitiously to hospital administrators, hospital administrators are looking for this kind of support. To a significant extent, they are captives of their own staff, their medical staff; they are captives of the chiefs of services and they really do not dare rock the boat. They are looking for some kind of support from the Government and this support from Government simply has not been forthcoming for the past 5 years for medicare, in our opinion.

Staff. This is somewhat of a self-serving question here. In its recommendations to the committee, the staff recommended that the Federal Government provide 90 percent matching funds under medicaid for personnel whose full time is spent in utilization and cost review, medical audit and fraud and abuse investigation. Would such increased Federal matching—we know the new bill which will be coming over does allocate 90 percent matching to a portion of that—would such increased Federal matching increase your capacity to do a better job in New York City, and if so, how?

Dr. Bellin. Unquestionably, we think this is a superb recommendation on the part of staff and we hope this recommendation is implemented. We, of course, hope that at the same time, the additional 10 percent would come from local government—by that I mean State government presumably. I think that, parenthetically, I might insert the following sociopolitical reality.

Historically, as far as governmental administration goes, all the way back to Nebuchadnezzar and the hanging gardens, the way of crippling programs is never to speak against the program; but if you do not allocate funds for it, then the program seems to disappear. I only fear that the 10 percent may not come forth. We occasionally run into this kind of a problem. I think that if this 10 percent does not come forth, we may be coming back to the Federal Government perhaps asking for more than 90 percent or asking the Federal Government to prod our State government into coming forth with that 10 percent.

Unquestionably, once we had the money and the resources, I think we would demonstrate very, very rapidly what can be done in this field. I say this despite the fact that it may sound arrogant, but when you start with a very, very low level of performance, you have to do better.

Staff. You indicated in your testimony data on quality of care lems in connection with reimbursing teaching or supervisory physicians under medicare and, to the extent that it existed under medicaid. Does the New York City Health Department have any position on that?

Dr. Bellin. Yes, we have been quite alarmed about this payment for supervisory physicians. Let me state, as a principle, a philosophical premise that we have attempted to adhere to; we think that, in this day

and age, professionals should not subsidize social programs. We feel that the Robin Hood philosophy of taking from the rich and giving to the poor is outdated and we think that services ought to be paid for and if they are going to be publicly subsidized services, they should be paid for by public taxation.

Having said this, the question then comes up, "How then, if we believe this, should people who are carrying on supervisory services be reimbursed for these supervisory services?" I think that the wrong way of going about this, and I am realistic enough to know that this is probably the way it is going to be adopted, because it is already adopted in medicare, is to pay on a fee-for-service basis for the patient who is hospitalized.

I think what we saw in medicare, for example, and that is where the pernicious technique began, was to pay physicians for supervisory services 80 percent of surgical fees and 100 percent for nonsurgical fees. This meant then that the physician was essentially a straw boss of a number of interns and residents in a hospital who carried on the bulk of the services and the physician then billed medicare for 84 percent of this if there were an operation and 100 percent if there were not.

We had the experience in New York City where we took the position, both in the department of social services and in the department of public health in the city, that we simply would not pay that kind of money. What happened was that the medical society did an end run around the city agencies, went to the State and the State came out with a policy—the State health department and State department of social services to pay for medicaid supervisory services precisely as medicare had been, based upon that precedent. We took the position subsequently in New York City that, notwithstanding the State's action, the city still would not pay and we have not paid up to now.

Our position is quite simple: We think people ought to be paid, but not on a fee-for-service basis in the hospital. We think something else ought to be worked out, either a salary basis or a fee per session, or some other kind of basis.

We do not in any way want to imperil the teaching program at the deservedly internationally known hospitals of New York City or elsewhere that are affiliated or associated with each of the medical centers. We want to maintain that type of teaching and do not want to jeopardize it.

However, I think a very definite Federal policy has to be articulated and we are not certain right now precisely what that policy is going to be, whether or not medicare or medicaid is expected to subsidize medical education. If it is, let's come out and say so. If it is not, then we have to isolate funds for medical education from funds for medical care. We find it is almost a mystical experience in administration in New York City to try to identify for any one individual who is allegedly working full time for any institution how much time he is actually devoting for care and how much time he is actually devoting to education and attempt to deal with it equitably. It is an impossible task. Heaven knows we have been working on it for a number of years and we think some kind of policy or direction has to come from the Federal Government on this.

Staff. Fine, that is all the staff questions for Dr. Bellin.

We have a few questions for medicenters.

In responding to Senator Williams earlier, you indicated that you thought your franchise holders were not required to purchase anything at all from you in the way of supplies or equipment, including furniture or anything of that sort. Does medicenters establish furniture or construction standards—that is, do you have requirements with respect to the size, weight, strength, and so on for furniture and equipment which must be met that might be such as to compel to any degree the utilization of your supply operations?

STATEMENT OF JOHN A. DeCELL—Resumed

Mr. DeCell. No.

Staff. You do not?

Mr. DeCell. I would like to say we do establish standards for construction and for items of equipment, both in quality and quantity. But they are readily available.

Staff. From other suppliers?

Mr. DeCell. That is correct, absolutely.

Staff. You mentioned in your statement that hospital costs have been increasing at more than 15 percent per year. What is the rate of cost increase of your facilities?

Mr. DeCell. This is an estimate. I think last year in our annual report our average charges were like $26, and as I mentioned in our most recent year they were between $30 and $31. The year before that, we were——

Staff. Excuse me. Does that mean that your costs are increasing at the same or a greater rate than hospital costs?

Mr. DeCell. I would suspect that we are subject to the same elements of cost increases as is the hospital—minimum wage increments, building costs increases. The obvious answer there, though, is if we are going to have the same percentage increases, let's incur most of them in the lesser cost facility as opposed to the acute care.

Staff. What is the average stay of medicare beneficiaries in your facilities?

Mr. DeCell. For medicare beneficiaries, I cannot give you the average through the whole system. I can give you the total length of stay for all patients. As I mentioned earlier, about 70 percent of the patients are medicare beneficiaries. And the average stay is 29 or 30 days.

It just so happened that last week I was in Boston and I was aking these questions of our facility there. They did break it out. For your information, the average medicare patient in that unit has a 21-day stay. Nonmedicare was 19 days. The average age in that facility was 54.

Staff. In the staff report, there was a fair amount of recognition of the problems of medicare: reimbursement and reporting requirements, redtape, and what have you. In your statement, you indicated similar concerns and suggested other means of reimbursement as a solution. But I do not think you really got down to the basic question before. Are you making or losing money with medicare?

Mr. DeCell. We are making money with medicare. The increment—my adviser here says I had better qualify that.

The increment is much too small. Conversely, cost-plus reimbursement is not to be desired from the program standpoint, and we are the first to recognize that.

STAFF. But the point is that the Federal Government, no matter how complex a reimbursement procedure it may devise, no matter how much paperwork it involves, is not paying less than cost? You are not operating at a loss with this type of patient?

Mr. DECELL. Not at a loss, but with reasonable occupancy levels the income is less than that which the private patient is expected to pay. Therefore, you are in fact doing what the law or the regulation says was not the intent of Public Law 89–97—that is, to impose on the nonmedicare patient a financial burden. To answer you specifically, we are not losing money. It is almost impossible to lose money under a cost-plus reimbursement.

STAFF. Did you say your average occupancy levels were about 70 percent?

Mr. DECELL. For facilities open more than 1 year, that is correct.

STAFF. How about facilities opened up for less than 1 year?

Mr. DECELL. They are built up starting from scratch. Our occupancy build-up is much slower than a hospital or a nursing home.

STAFF. What is the average payment by medicare on a per diem basis of say less than 30 percent occupancy or—obviously, what we are getting at is the unoccupied bed cost of medicare?

Mr. DECELL. No question about that. That is why we feel that the incentive reimbursement is one approach to that. At the present time, we are on the basis of reasonable cost.

STAFF. But the question is this: Is medicare in certain of your facilities and for certain periods of time paying $50, $80, $70 per day?

Mr. DECELL. I do not have the figures readily available. They are paying reasonable costs in the facility as audited.

STAFF. Does that reasonable cost go up to $50, $60, $70 a day for a low occupancy facility?

Mr. DECELL. I think what you are asking is does it exceed charges at some point. The answer to that is "Yes." Does it go to $50, $60? I do not know.

STAFF. Those figures are strange to you? They do not sound as if——

Mr. DECELL. I have no reason to know what the individual reimbursement would be. Our operations division would. I do not know just off the top of my head.

STAFF. That pretty much finishes what we have.

In your statement, you referred to the staff as having recommended doing away with the 3-day minimum hospital stay for ECF eligibility.

Mr. DECELL. No, I said you had alluded to the cost-savings. In fact, I think you were commenting on a statement submitted by a commercial health insurance company. I can find that in your staff report, where they in fact computed the cost-savings of a minimum hospital stay and said the requirement for 3 days' hospitalization would be more cost to the program. I did not mean to imply that you recommended it. If I said that, we would like to correct the record.

STAFF. But you know that the program is an acute care program and that one of the criteria of acute care is the hospital episode or acute episode. But assuming that the Government did away with the 3-day prior hospitalization requirement, what would prevent those same extended care facilities from becoming filled up? In other words,

what screening mechanisms would there be to prevent those same facilities from being filled up with patients who in fact might not really belong in any institution?

Mr. DeCell. I am sure that the utilization review that already exists in extended care, which by and large is much better than that which exists in acute hospitals, would come into play. If in fact, you could establish a financial incentive to the physician, he would have every reason to keep them out of any type of institution or to get them out as quickly as possible. The answer to your question is utilization review.

Staff. That utilization which is being undertaken by the intermediary?

Mr. DeCell. No; undertaken by the provider.

Staff. And utilization review in your facilities, is that conducted by owners of the facilities, franchise holders?

Mr. DeCell. Negative.

Staff. You do not permit anybody to serve on utilization review who is an owner?

Mr. DeCell. No.

Staff. Why?

Mr. DeCell. Disinterested physicians—because the SSA has issued directives concerning the makeup of utilization committees for extended care facilities.

Staff. How many of those facilities were represented on the utilization review committees by physicians who were the same people who had admitted the patients?

Mr. DeCell. I think we would propose that owners not be represented on the utilization review committee and that is the directive that has been established for extended care facilities.

Staff. I believe it is now not more than one owner who may serve on the extended care facility utilization review committee.

Mr. DeCell. I stand corrected.

My counsel says that the most recent regulation says none. There is no reason why that should be changed. We think that utilization review has been strengthened in the extended care facilities. It is unfortunate that it has not been strengthened in the acute facility also.

Staff. Your views on that point contradict those of the Federation of Hospitals, which as you know——

Mr. DeCell. I understand that. That does not surprise me.

Staff. Thank you, gentlemen.

At the direction of the chairman, the committee will meet tomorrow at 10 a.m.

(Whereupon, at 12:25 p.m., the hearing adjourned.)

MEDICARE AND MEDICAID

WEDNESDAY, JUNE 3, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Abraham A. Ribicoff presiding.

Present: Senators Ribicoff, Gore, Hartke, Williams of Delaware, and Bennett.

Senator RIBICOFF. The committee will be in order.

We have a problem. The Senate will be voting at 11:30 and we will have to suspend, and then there will be a joint session of Congress following that. We would hope that all of the witnesses, instead of reading their entire statement, would summarize their position. The entire statement would then go in the record; the witnesses to remain, after we suspend, to answer questions by the staff.

The first witness will be Mr. Keith E. Hutson.

STATEMENT OF BERKELEY V. BENNETT, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES; ACCOMPANIED BY KEITH E. HUTSON, PRESIDENT AND CHAIRMAN, BOARD OF AMERICANA NURSING CENTERS; CHARLES Z. WICK, PRESIDENT, UNITED CONVALESCENT HOSPITALS, AND MISS ELIZABETH CONNELL, PUBLIC RELATIONS DIRECTOR

Mr. BENNETT. Mr. Chairman and members of the committee, we appreciate this opportunity to be with you today. We will try to keep our presentation short as you have requested. I will talk a little bit about the background of the National Council of Health Care Services. Mr. Wick will discuss the multifacility health care industry, and Mr. Hutson will talk about some of our suggestions for changes in the medicare and medicaid program.

Mr. Chairman, I am Berkeley V. Bennett, executive vice president of the National Council of Health Care Services. On my right is Keith E. Hutson, president and chairman of the Board of Americana Nursing Centers, a large privately-held multifacility company headquartered in Monticello, Ill. Mr. Hutson, who is a lawyer, is widely regarded, both within the industry and outside it, as an expert in the extended care portion of the medicare program. He has been involved in the industry for 10 years, since 1960 when he founded Americana Nursing Centers in an attempt to meet the growing need for high quality health care facilities.

On my left is Charles Z. Wick, president of United Convalescent Hospitals, headquartered in Los Angeles, Calif. Mr. Wick has been in the industry since 1961, when he formed United Convalescent Hospitals after several years of research to provide top quality nursing care for a relative. This publicly held company presently operates 20 extended care facilities in nine States.

Mr. Wick, a lawyer, was appointed to President Johnson's task force on nursing homes and related facilities in 1966. He is a member of the American Hospital Association's Type II Governing Council.

On my far right is Miss Elizabeth Connell, public relations director of the council.

For the past 25 years, my experience has been concentrated in health-related industries and association management, with emphasis in the nursing home field. I have served as executive director of the New Hampshire Association of Licensed Nursing Homes, the Vermont Pharmaceutical Association, the American Society of Consultant Pharmacists, and the Vermont Nursing Home Association. In this capacity I personally set up uniform financial records for some 60 nursing homes in Vermont.

In a recent essay on "Nursing Home Standards—A Tragic Dilemma in American Health," Jordan Braverman reports:

> Another glaring licensure deficiency pertains to the whole area of health costs. At a time when the costs of health care, generally, and the costs of the Medicare program in particular, are escalating rapidly throughout the nation; at a time when the determination of reasonableness of health care costs is in question and difficult to determine; at a time when there is a lack of uniformity among the accounting procedures of nursing homes, only one state, Vermont, has made it a licensure requirement for nursing homes to maintain uniform cost records as prescribed by the State Licensing Agency. Whether the regulation is able to achieve its desired goals depends upon those involved in the program, but, thus far, only one state in the country through law has attempted to bring fiscal order out of financial chaos.

I was responsible for this step and therefore would like the committee to understand my longtime concern with costs and good management.

In addition, I have served as nursing home consultant to Johnson & Johnson, and the National Wholesale Druggists Association, and presently am on the editorial board of Modern Nursing Homes magazine. I am a member of the Small Business Administration's (Vermont) Advisory Council and have been appointed to the U.S. Public Health Service's task force on health administration.

The National Council of Health Care Services, organized in October 1969, is an association of multifacility nursing facilities representing major companies in the industry with an aggregate estimated investment of $550 million. Approximately 90 percent of the council's member companies are publicly held. Public companies must come under closer scrutiny than the sole proprietorship and partnership.

As a condition of membership, each company in the council owns and operates at least three nursing home facilities with a minimum of 300 certifiable beds. All told, council members provide close to 70,000 licensed beds. Members of the National Council of Health Care Services are united in a common objective: To promote and maintain a professionally and economically sound health care program, with emphasis on providing the best possible care for the patient at the lowest possible cost.

Our members recognize that their first obligation is to the patient, and health care facility that fails to show proper concern for the patient's welfare does not deserve to stay in business.

In the testimony there is a quotation from a letter from David A. Jones, chairman of the board.

Senator RIBICOFF. The entire statement will go into the record, so you do not have to feel compelled to read the entire statement.[1]

Mr. BENNETT. We will be glad, Mr. Chairman, to answer any questions of the committee or the staff.

To continue though, I would like to report in regard to the excellent staff report of the Finance Committee and, in particular, on page 135 concerning chain operations. Mr. Wick will now discuss some specific areas of management.

Mr. WICK. Thank you, Mr. Chairman. I shall try to summarize here in the interest of time, as you request.

I am Charles Wick, president of United Convalescent Hospitals in Los Angeles, Calif., a publicly held company. I, too, should like to congratulate the staff on an excellent report representing prodigious effort, and speaking as a professional in our industry, I can affirm that with a very few exceptions they have done an excellent job in developing obscure and obscured facts that are pertinent, and they, in most instances, almost in all instances, have refreshingly separated opinion and conclusions from the facts upon which they produce those conclusions.

Just to summarize my statements here, sir, I believe that the private sector, the publicly held companies offer the optimum opportunity for the Government and the taxpayers and the patients to be able to achieve cost-effective health care quality.

In World War II, under Mr. Roosevelt, when they wanted to build 50,000 airplanes in 1 year, and provide synthetic rubber, it was the free enterprise sector that marshaled the best brains and disciplines available and wedded them into a system of delivery.

The Mom and Pop operators have done an excellent job in most instances. However, the free enterprise system of management bringing together a wide spectrum of disciplines into one effective delivery, I believe historically in every field is representative of the best and most consistent quality under the most effective price.

Senator BENNETT. Are you saying that Mom and Pop operations are not free enterprise?

Mr. WICK. No, sir; I am not.

I am pointing out here that the functional value to the goals of the country are best represented at this time, when the health care service has become a uniformly large volume business, representing a significant portion of our national gross product, that the same type of systems in fulfilling those goals, that the automobile industry and other industries use, must be brought to this.

In the automobile industry, when it was evolving through the Mom and Pops of individual entrepreneurs, they performed a random type of jerrybuilt approach to this goal, and there were no automobile people on the assembly line until they were trained and created in response to a demand.

[1] See p. 583.

Similarly, the professional managers of the public companies, large multifacilities, have recruited the type of capital, the type of rewards, in profit-sharing, and stock operations, that may be a rewarding by-product of services they will perform.

Senator BENNETT. It is a long answer——

Mr. WICK. I beg your pardon, sir.

Senator BENNETT. You have given us a long answer to the question. I think you will want to re-read your testimony and take out the statement which says very plainly to us that it was not until free enterprise replaced Mom and Pop, that things began to happen.

Mr. WICK. Well, I certainly, if that is in there it was not intended, and you are looking at a Mom and Pop. I started this company in 1961 when I got mad and could not find a nursing home for somebody very close to me, and put my own money in this kind of thing and developed a number of facilities over a number of years. So I appreciate very much your suggestion. That was not intended.

Regarding personnel, the health care industry is relying upon personal services to a large extent and, as you know, there can be no technological breakthroughs in people other than through training aids and the type of incentives and motivations that will make people more productive.

In our business, essentially, we are dealing with a 1-to-1 relationship at the patient level. Therefore, through the free enterprise or any other system where you can motivate managers or trainers to be able to get the highest productivity of a consistent quality from people, then you are approaching your goal, and we believe that we have the resources to do that, and certainly hope that we can.

Uniform financial reporting, all controls, as you know, in a field involving millions and hundreds of millions of dollars are responsive to, equated by and controlled by accurate and valid financial and other reporting systems and statistics.

In design and efficiency we, in our company and other companies, seek to bring to each new set of plans remedial approaches reflecting what we have learned that have been expensive in the nature of nursing stations built too far from patients and other types of experience factors that can be incorporated in prospective development.

Public versus the private sector. The alternative to the poliferation of health care services delivery would be other than free enterprise, the private sector, the governmental sector, and it would seem to me that the Government has not gone into the airline business or trucking business, but seeks to make those particular businesses responsive to national goals in the most effective manner.

Senator Williams is quoted in the staff report, if I may just read a short section:

> Furthermore, if a chain owns an extended care facility as well as a hospital, it can see that patients go from its hospital to its nursing home. A chain may also own pharmacies or sell hospital supplies to a ready-made captive market in its hospitals and nursing homes at a high noncompetitive price.

I certainly deplore, Senator Williams, any type of happening such as you indicate here, and it does happen. However, I should hope that we would not emphasize abuse as being the standard principle that, by which we would equate the system. I think the system is meritorious.

All well-motivated people who are addressing themselves to survival in our business must recognize that abuse can only breed regulatorily repressive conditions and public condemnation that certainly will not permit an economic survival.

Senator WILLIAMS. Are you suggesting that I made that as a broad statement and did not recognize that these were isolated cases of abuse?

Mr. WICK. No, sir.

Senator WILLIAMS. Are you suggesting that abuses should be swept under the rug?

Mr. WICK. I do not.

Senator WILLIAMS. What are you suggesting?

Mr. WICK. I was seeking to cite your assertion there as a positive value and also complimenting you. When I get back to Los Angeles, I am going to have to get some kind of a course to make sure that I rub people the right way. I am sorry. I did not mean it that way at all, sir.

Senator WILLIAMS. I just wanted to get it clear.

Mr. WICK. Yes, sir, I am glad you did.

Senator WILLIAMS. I just did not want to leave the impression that any of this abuse should be swept under the rug. It should be put on top and exposed. We can clean it up better that way.

Mr. WICK. The reason I commented on that is, we would like to help you. We from our perspective obviously were biased. It is your job to rip away whatever wrong emphases bias indicates so that you can get at the truth.

We feel that we are doing a job and should do a job that is free from abuse and should provide a value.

However, we must contend with broad propaganda frankly and a sensationalism that seeks to tar us with a brush in many instances that is just completely unrelated to the facts and it clouds the public mind. It clouds the congressional mind with just what does go on behind that mass of abuse and that is what I was seeking to penetrate.

My fundamental suggestion, if I could leave you with only one thought that might be helpful to you in seeking to find what would be most appropriate to answer this conundrum of health care services, would be to invite the people representative of the public companies. the multifacility groups, and we can help you with early detection of abuses. This is our business, and we have, not using a standard of morality which I hope we all address ourselves to, but just from a pure survival standpoint, we cannot stay in business unless we can do a good job and unless we do not become corroded with the type of reprehensible reaction that abuse dictates.

A brief word here about stock prices. Unfortunately, the public and the inflationary stock market seized upon the health care industry, which for the first time could address itself in a public stock form, with a ridiculous run-up of these prices. They are reaping their wild wind, the people who speculated, but, if I may urge, that whether or not the rubber companies' stock price is high or low, it does not have any effect upon the delivery of that tire in the competitive arena to that customer.

I flew on Western Airlines the other day and learned that they had lost $2 million this quarter. However, the depressed stock price was in no way correlated with the service they had to provide in a competitive market.

So I believe that the furor and concern about the stock prices were that they just ridiculously overpriced and their subsequent demise in no way affects health care.

It is the competition for the doctor's favor, the family's favor, the medicare intermediary's omniscient eye that we must address ourselves to.

I would urge, and this is my conclusion, by the way, that very few of the public companies are making any profits in the nursing home aspect of their business. That is something that we can document, I am sure, elaborately for the staff and to their satisfaction.

I think there is, with medicare shrinking their benefits in the nature of much lower volume after suggesting that there would be a big need when we were surveyed originally by medicare and we geared up to it, there has been a very severe economic back-lash, and I think you are going to see many of these companies going broke sometime soon, and I think as their annual reports come out this year, there will be a very cogent demonstration of that particular fact.

About the abuse, I think that we can efficiently bring the pharmacy, the development of purchasing, to one central place, help the medicare and/or Government through questionnaires, the answers about abuses might provide suitable penalties, as the Internal Revenue does, be able to disclose completely the efficiency that can be gained by our bringing these different services together after saving a multitudinous amount of overhead, where we can make a small margin on each of these overheads which, in their totality, can mean a lower cost to the beneficiary and the taxpayer.

In summary, I would like to suggest to you the quality of health care provided the citizens of this country under medicare and medicaid and ultimately to every man, woman, and child in the United States will always depend upon the full and proper use of the knowledge and resources and dedication of those of us in the private sector and, believe it or not, I think I condensed my statement and I am sorry if it was long-winded.

Thank you.

Mr. Bennett. Some of the things that Mr. Wick has referred to we will be glad to answer in questioning later. We are concerned very much with the fact that public companies have contributed a great deal to the money market in building health facilities which may not otherwise have been available.

Mr. Hutson will discuss some of the solutions to the problems which have been discussed about the proper payment mechanism.

Mr. Hutson. Mr. Chairman and member of the committee staff, my name is Keith Hutson, I am president of Americana Nursing Centers. We operate 36 extended care facilities with over 3,000 beds in Illinois, Indiana, Iowa, Nebraska, North Dakota, South Dakota, Wisconsin, Minnesota, and Florida.

Senator Bennett, these facilities are all, each one of them is a small business enterprise. We think we have the best of both worlds

in that we have the dedication of the local staff and the local administrator, the Mom and Pop, so to speak, in the local communities, and also a staff of specialists at central office to help them with their specialized problems.

As president of the national council, I have compiled a rather extensive treatise on medicare's institutional care programs. We strongly suggest sweeping reforms in the principles under which these programs are administered. To date, most of our effort has been directed to medicare problems. Medicaid problems are now coming to the fore and we will have some suggestions on those in the very near future.

Most of the medicaid problems can also be traced largely to unworkable principles, the two programs do have much in common.

Our medicare suggestions are contained in some documents which you have, which I am not going to go into in detail because it will take too long. We have a one-page summary called "The Case of Incentives" in your folder and then a detailed booklet also called "The Case for Incentives" that I would commend to your attention and that of your staff. It may have some helpful suggestions to you.*

It is interesting how much our "Case for Incentives," which was prepared ahead of the receipt of your staff report, parallels the finding of your staff report, and we agreed in large measure with almost all of the recommendations of your report.

I am going to summarize very quickly some of the areas of agreement and a couple of areas of disagreement, and conclude my remarks in that fashion.

I think you are all aware of the medicare costs skyrocketing primarily because the present program principles encourage overutilization of health care services and discourage efficiency.

So it is your job and our job in the industry to help find out how medicare can encourage patients and physicians to seek and providers to provide health care which is the best combination of quality and price.

Now there is no great problem in keeping quality high. The present incentives and controls are doing a fine job of that and I am going to pass over those completely from our report because there is no need to dig into them.

But the question of how to keep costs down is where the principles need a total overhaul.

There are in any business setting natural incentives for economy, and we would urge the principles be adopted that do provide these natural incentives.

First, an incentive to provider to be maximized by prospective rates.

This is the one primary area of disagreement that we have with the staff report. As we understand the programs for reimbursement that are being designed or are being looked at at the present time, they do not put the emphasis on prospective rates that we think is vital in order to give the proper incentives to the provider.

We are perfectly willing and actually eager to have the Government take their savings first in the form of ceilings, some sort of a negotiated top rate for the medical program, and then we believe

*The material referred to was made a part of the official files of the committee.

that we can deliver quality health care well within those ceilings, creating further savings for the Government by competitive factors, good management factors, and in turn the good providers, the efficient providers, providers within this area will be awarded the profits and those inefficient will suffer losses and will fall by the wayside.

So first then, the natural incentive to economy to the provider of a prospective rate we believe absolutely should be related to charges and not to costs, because this will eliminate many of the costly audits and many of the regulations that are unnecessary in a prospective rate system.

Also, as a safeguard, we believe that these rate ceilings in the medicare program must be established, tied to some logical indicator, probably different for each county or each area within a geographic region, and we have suggested that the average daily medicare charges in ECF be established prospectively each year, and as an adjusted indicator three-quarters of 1 percent of the area's per capita income figure as tabulated by the Government for the latest available prior year.

Incentives to provider is only one of the three major incentives that we think are necessary. The patient must have incentives to seek the appropriate level of care and to seek the best combination of quality and costs within that level.

Presently, he has no such incentive. He has a flat rate type; it is called coinsurance or a deductible, where his costs are the same whether he is in a $50 ECF or a $15 ECF, and we believe that—your staff report has shown that some 18 to 19 percent of the cost of the program in ECF is presently borne by the patients under this flat rate, which is now $6.50 per day after the 20th day.

We believe the same 18-, 19-, or a 20-percent coinsurance factor would create the incentives necessary for the patient to seek the proper level of care and the proper facility within that level of care.

The third major incentive is really in the nature of a disincentive. We think incentives for economy must be served by the physician. This was a major point made in your staff report, and we agree. We believe that overutilization is presently encouraged by the physician largely because of the uncertainties of the program, and we believe that the physician should be given the total responsibility within the certifying physician's period of review and medical audit, and with the responsibility should go, with this responsibility should go the accountability, they should make the decision and they should be accountable for abuses, and we believe if a physician has this responsibility, he will welcome the accountability.

We have a number of other minor or lesser recommendations that are shown in our full treaties which I will not discuss at this time.

I believe then that we can summarize our most important recommendations in a single sentence. We believe that medicare payments should be limited to 80 percent of the provider's established charges for covered services up to a daily ceiling of the three-quarters of 1 percent of the area's annual per capita income, with a beneficiary paying the balance. If he is medically indigent, the Government must pay the balance and must participate in the decisions that affect costs.

Physicians should make medical judgments and be accountable for abuse of their authority.

Senator Ribicoff. Thank you.

Senator Williams?

Senator Williams. Mr. Hutson, Mr. Wick properly quoted from the staff report wherein I stated that if a chain holds an extended care facility as well as a hospital, it can see that its patients go from the hospital to its nursing home. The chain may also own pharmacies or sell hospital supplies to a readymade captive market in its hospitals and nursing homes at a high noncompetitive price.

He is correct in that quote because one of the concerns of the committee has been that there may be a potential opportunity for self-dealing here.

Do you think this is a danger we should guard against?

Mr. Hutson. Yes, I think there is some danger there. I do not believe it is a real danger in the medicare program because, as it is presently constituted, I do not believe anybody is going to be able to go undetected in such abuses.

Under the related vendor regulation, there are so many safeguards that the goods and services must be provided on a quasi-competitive basis or tantamount to a competitive basis, that I believe that medicare will ultimately only pay the costs of these related organizations' goods and services.

Now, however, I believe if we go to a prospective rate with ceilings that these abuses will just vanish. There will be no opportunity to profit in the third party payoff program from fraud or such abuses because the ceilings will not leave room for exorbitant profits.

Senator Williams. I mention this because one of the principal concerns about the so-called health care conglomerates is the possibility of such self-dealing between related organizations such as hospitals, nursing homes, supply houses, financial organizations, and so forth.

Do you have any recommendations that would prevent any such self-dealing between those organizations and financing companies?

Mr. Hutson. Well, in the first place, I believe disclosure is vital. I believe that if each provider is forced by the free enterprise system and by medicare ceilings as a backstop control to provide health care at the lowest possible dollar in order to get patients—or in order to remain within that ceiling, that then these abuses will be discouraged by the business system as well as by the regulations.

I think you need less regulation in a truly competitive free enterprise situation.

Senator Williams. Last December, the Chicago Tribune and the Chicago Sun-Times carried stories of your own involvement with a small business investment corporation, the Illinois Medical Capital Corp., which is now in receivership. To what extent were you involved in that, either borrowing money from or loaning money to it?

Mr. Hutson. At the present time we are in negotiation with the Small Business Administration on the settlement of any disputes that may result from that.

I would be happy to furnish you with any of the materials that do pertain to this particular situation. It would be a tremendously long story to go into here, and might not be appropriate in view of the negotiations.

I would say that as a generality it is my belief that everything that Americana, my company, or I as an individual, did in any dealings with Medical Capital Corp. were legitimate and within the letter and spirit of the Small Business Administration regulations.

Senator WILLIAMS. I understand there may be negotiations, but I do not see why we cannot discuss this just briefly. We do not have to go into a lot of it. Were you a principal factor in the Small Business Investment Co. to which you referred?

Mr. HUTSON. The Medical Capital Corp., I was not an owner or a principal.

Senator WILLIAMS. Were you in any way involved or connected with this company?

Mr. HUTSON. I was attorney for Medical Capital Corp. at one time.

Senator WILLAMS. Were you manager of the company?

Mr. HUTSON. No.

Senator WILLIAMS. Small business company?

Mr. HUTSON. Small business investment company?

Senator WILLIAMS. Yes.

Mr. HUTSON. I was its attorney, not its manager.

Senator WILLIAMS. You were just its attorney. You should then know whether this company, on your advice, loaned some of its money to one of your nursing homes.

Mr. HUTSON. Not on my advice.

Senator WILLIAMS. No loans to related companies?

Mr. HUTSON. Medical Capital Corp. did lend some money to some landlord companies of subsidiaries of Americana Nursing Centers, Inc., and did lend some money to a predecessor company of Americana Nursing Centers, Inc., North Carolina.

Senator WILLIAMS. Do I understand you did not have any contractual arrangements with this small business investment companies? How about other small business investment companies? Are you connected with any other small business investment companies?

Mr. HUTSON. Yes. At one time I was counsel for half a dozen small business investment companies, and I was a major stockholder and president of one at one time. I also owned a company which, at the suggestion of the Small Business Administration and with their consent, served as common manager for three small business investment companies in an administerial sense.

Senator WILLIAMS. You were the common manager?

Mr. HUTSON. I was not, but my company was. I owned the company.

Senator WILLIAMS. What was the extent of the lending, of these small business investment companies to nursing homes with which you were affiliated?

Mr. HUTSON. I do not have the figures available with me.

Senator WILLIAMS. Was it $10 million?

Mr. HUTSON. I would not know. It was substantial but I do not have any idea what the dollar figure was.

Senator WILLIAMS. You do not have any idea whether it was $5 or $10 million?

Mr. HUTSON. I would not have any idea what the figure was. It could not have been that high because these small business investment companies were not that big.

Senator WILLIAMS. What rate of interest was paid when your loans were negotiated with these companies?

Mr. HUTSON. Well, if you mean what rate of interest was paid——

Senator WILLIAMS. What rate of interest did the SBDC's charge your nursing homes?

Mr. HUTSON. Were paid by these various nursing home landlord corporations to these small business investment companies?

Senator WILLIAMS. Yes.

Mr. HUTSON. It was a varying rate of interest, as I recall. It started out at one figure and went to a higher figure with an average of something like 10 percent.

Senator WILLIAMS. What was the range?

Mr. HUTSON. I think it was 6 to 12.

Senator WILLIAMS. 6 to 12 percent.

To a large exent the small business investment companies were financed by loans from the Small Business Administration, were they not?

Mr. HUTSON. Yes, sir.

Senator WILLIAMS. What rate of interest were you paying the Small Business Administration?

Mr. HUTSON. Five to five and a half percent, I believe.

Senator WILLIAMS. Five to five and a half. You were practically doubling your rate of interest. It was really Government money to a large extent, was it not? That is the reason I felt we could discuss it.

Mr. HUTSON. Yes, that was the purpose of the SBIC program.

Senator WILLIAMS. What percentage of the money that these various small business investment companies borrowed from the Small Business Administration were subsequently loaned to nursing homes with which you were affiliated, which you controlled or for which you were acting as attorney?

Mr. HUTSON. I am sure they were different percentages at different times and I would not have the figures in my head.

Senator WILLIAMS. Was it most of it?

Mr. HUTSON. At one time or another, I am certain it was.

Senator WILLIAMS. Do you think that that would raise a question of self-dealing?

Mr. HUTSON. Well, it might. It has to some of the people in the current Small Business Administration. It was done in the full light of day under the rules and regulations of the Small Business Administration as they were in effect at the time.

The regulations changed, have been changing, the self-dealing, those things have been changing over the years. When they started what was an investment that was encouraged, or even—permitted or encouraged in 1961 would be prohibited in 1966 or 1969.

Senator WILLIAMS. What was the date of these arrangements with the Small Business Administration? Was it 1961, or more or less 1965 or 1969? Were they not recent loans?

Mr. HUTSON. No. These were, these small business investment companies were formed in 1961, 1962, and 1963, perhaps, and the bulk of their money was loaned during that period of time. They have been fairly dormant in recent years.

Senator WILLIAMS. Then does the Small Business Administration agree with the statement you just made that you were operating within

the rules prevailing at the time or do you thing you abused those rules?

Mr. HUTSON. This has not been determined. It is a matter of some dispute at this time.

Senator WILLIAMS. If it is a matter for dispute, do we take it that you think they were in violation of the rules and they think they were not, or do they think that you violated the rules and you think you did not?

Mr. HUTSON. They suspect there were violations of the rules and they have been looking into it in some depth.

Senator WILLIAMS. And you do not have any idea as to the extent of the obligations of the various small business companies today?

Mr. HUTSON. I know they are diminishing steadily, but I cannot tell you at the present time.

Senator WILLIAMS. Can you tell us within a few million?

Mr. HUTSON. I could do some figuring perhaps and get the figures to you. I do not have these figures in my head.

Senator WILLIAMS. Do you mean to tell me that you cannot even estimate within a couple of million of what you may have loaned, or a million?

Mr. HUTSON. I could, giving it some thought I am sure, but I cannot off the top of my head.

Senator WILLIAMS. Would it help you if I told you it was $5½ million?

Mr. HUTSON. I will not be able to answer that question without giving some thought and maybe checking some records.

Senator WILLIAMS. Considering that this is under dispute, I am somewhat disappointed that you do not seem to know any more about this operation, because it is one that has given some of us just a little bit of concern because it does involve the question of potential self-dealing. Since this is Government money that was borrowed from a Government agency, I though maybe you could help us clarify this. That is the reason I thought you were here this morning.

Mr. HUTSON. Well, I am here today to talk about the medicare program. If you would like to talk about——

Senator WILLIAMS. This is the medicare program. One of the earlier witnesses compared it to the airlines and the automobile industry and all comparable parts of the competitive free enterprise system—to an extent it is comparable but there is this vast difference: The case we are discussing here is apparently one involving Government financing of the industry itself on one side, and on the other side the Government providing 80 to 90 percent of the customers. So this is not exactly a free enterprise system.

The Government or the taxpayers are involved at both ends, and I think it is quite proper that we find out whether they are being properly protected at both ends or being neglected. These small business investment companies of which you were the manager were borrowing money from the Government at 5½ percent interest, and were lending it to companies with which you were affiliated.

One of these small business investment companies is in receivership, as I understand it, and to that extent there is a potential loss to the taxpayers. I think these are pertinent questions.

Mr. HUTSON. Taken out of context, Senator.

Senator WILLIAMS. Well, straighten it out.

Mr. Hutson. Taken out of context, a number of these things can appear damaging.

The Small Business Administration was very heavily involved, both to direct loans and to the SBIC program, with the nursing home industry for a number of years.

Now, the SBIC portion of the program is rapidly getting out of the nursing home industry as fast as they can. This was, at one time being perfectly legitimate and proper, it later was frowned on, and this is a matter of considerable confusion. It has been, I would assure you, the Small Business Administration is representing the Government's best interests and trying to arrive at the proper course of action, and that the companies that borrowed money from the SBIC's, on the other hand, are paying back the loans as rapidly as they can in order to eliminate any question of conflict of interest.

Senator Williams. But I understand, according to your statement—if I misunderstood you, you can correct it—the bulk of the money was loaned to your own companies.

Mr. Hutson. That is not quite correct.

Senator Williams. Well, as I understood it, and correct me——

Mr. Hutson. You said it in that fashion.

Senator Williams. The amount of money borrowed from the SBIC's?

Mr. Hutson. I might have agreed with you.

Americana Nursing Centers, Inc., is an amalgamation of a number of former companies and, if you look at it at the present time, it may appear that there has been a great deal of affiliation that has not in fact existed until the time of the amalgamation. It is a very complicated matter and, as I say, it is in negotiation at the present time. I would be happy to try to clarify anything I can for you from memory or to gather all the information I can in the way of exhibits and submit them to you.

Senator Bennett. If the Senator will yield, I am a member of the Banking Committee, which handles the problems of the SBIC's.

The theory of the SBIC is that it provides equity capital, not debt capital. Did you deal in equity capital in these transactions or did you use the SBIC device to loan money to yourself?

The fact that you gave an answer saying that you loaned it at 10½ percent interest would indicate that you used it improperly to provide debt capital and that the SBIC's did not acquire equity capital.

Mr. Hutson. No; this is not correct, sir. I may have given the wrong impression.

At the time I was involved in the small business investment company, directly involved in it, it was our policy to lend money on convertible debenture bonds which are of an equity security and this, I believe, is the practice, or was at the time the practice, of almost the entire SBIC industry. You lend money to a small business concern, and you are a debtor until you elect to convert into capital stock. You are a creditor until you elect to convert.

Senator Williams. Are these loans of yours all convertible debentures?

Mr. Hutson. I have to clarify your question.

I was a stockholder of one SBIC.

Senator Williams. Just answer the question.

Senator BENNETT. Regardless of your relation with either company, did you deal exclusively in convertible debentures or did the SBIC get convertible debentures for all the money it advanced?

Mr. HUTSON. The SBIC, of which I was a part owner; as far as I know, all the other SBIC's principally used convertible debentures; there were stock and occasional direct notes.

Senator WILLIAMS. To what extent would they take notes?

Mr. HUTSON. I do not know that. The one I am most familiar with is Capital Service Corp., and I do not know that it had any direct notes or, if it did, it had notes, debt securities in some proportion.

It was our policy to always seek an equity position in any small business concern in which we made an investment.

Senator BENNETT. With specific respect to the SBIC and Americana, did you get convertible debentures from Americana and its related companies or were those the areas in which you had ordinary debt notes?

Mr. HUTSON. Americana Nursing Centers, Inc., is successor to Americana Nursing Homes, Inc., or a division thereof. Americana Nursing Homes, Inc., did not have any money borrowed from Capital Service Corp. after I bought into Capital Service Corp.

It did prior thereto have a combination, as I recall, of notes and convertible debentures.

Senator BENNETT. Taking the whole period of time into account, did the Americana group—regardless of the name you had for it at the time—did they deal with the SBIC's on any basis other than convertible debentures or did some of the SBIC money get into that group in some other form?

Mr. HUTSON. My recollection is that some of the predecessor companies of present Americana or its present subsidiaries, and some of the landlords, did borrow some money on notes from one SBIC.

Senator WILLIAMS. How much?

Mr. HUTSON. I do not know.

Senator BENNETT. What proportion of the total financing?

Mr. HUTSON. I do not know.

At the outset it was all convertible debenture bonds, as I recall, and then at a later date a portion, some additional money, was loaned to these small business concerns on straight notes, as I recall.

Senator WILLIAMS. You have been connected with Americana how long?

Mr. HUTSON. Well, I have been with Americana Nursing Centers, Inc., since its incorporation, I believe in 1966, and with predecessor companies in some capacity as consultant or other capacity since 1962, I believe.

Senator WILLIAMS. And you are its principal officer?

Mr. HUTSON. I am now chairman of the board and the president.

Senator WILLIAMS. And have been the principal officer throughout?

Surely you know more about the business of that company than you are indicating. I have a lot more respect for you than that. I have tremendous respect for your knowledge.

Mr. HUTSON. Senator, I am not trying to be evasive and I am not trying to be coy. I have at this time a rather large company with 115 employees in the central office, with seven division heads that report to me. One of them is responsible for financial matters of the company,

and he is the chief financial officer of the company, and I have general knowledge of what all these divisions are doing but I cannot be specifically informed on all of them.

Senator WILLIAMS. Illinois Medical Service Corp.—the corporation that went into receivership—what type of securities did they have?

Mr. HUTSON. Again I am going to have to speak to my best recollection. But I believe that—by the way, it was Illinois Medical Capital Corp., at one time. It dropped the "Illinois" when it went into some investments in Alabama and Georgia. The bulk of its portfolio in the Midwest—Illinois, I believe—was in convertible debentures and some notes, and in basically good investments. That is not the reason for its receivership.

When it dropped the "Illinois" from its name and went into——

Senator WILLIAMS. It has been suggested that you were planning to go public. Is there any accuracy to that?

Mr. HUTSON. Americana Nursing Centers is planning to go public. We investigated it, and we made some preliminary, did some preliminary work toward that goal. This was in 1966 or 1967.

Senator, I did not complete the answer to your other question.

Senator RIBICOFF. Would you be willing to come back at a later date and bring your books and records with you so you could properly answer the questions that Senator Williams and Senator Bennett have put to you? The committee reporter will give you a transcript of this testimony so you will be able to see what the questions are and what is expected of you. Would you be willing to do that?

Mr. HUTSON. Yes, sir.

Senator RIBICOFF. All right.

Senator WILLIAMS. This would mean we would want the records of the Americana Foundation, we would want the records of the small business investment companies with which you were affiliated as well as the records of your own company in order that we can determine the relationship between the group.

Now you would be willing to furnish all of these records and come back and answer the questions at a later time?

Mr. HUTSON. Yes, sir, they have been audited in depth by two certified public accounting firms and by the Small Business Administration, and if you would like to go into them also, I certainly think that would be appropriate.

Senator RIBICOFF. All right.

Senator Hartke, do you have any questions of this witness?

Senator HARTKE. No.

Senator RIBICOFF. We will arrange with you, sir, a mutually satisfactory date for you to come back and answer those questions.

Senator BENNETT. Mr. Chairman, I have one question of Mr. Wick. We went past him.

On page 10 of the material that we have, you are projecting the idea that because you have an integrated system that you can purchase equipment and supplies at a lower rate, and you say:

> One example is purchasing patient vests. A local distributor's price is $8.40 each. By buying through centralized purchasing, the price is $5.85 delivered, or a saving to the patient or third party of $2.10 each.

Mr. WICK. That is right.

Senator BENNETT. Can you demonstrate that savings actually existed or that the charge to the payer was based on the $8.40, the higher price, on the ground that your competitors who had to buy at $8.40 charged the larger amount?

Mr. WICK. I am speaking here—we are speaking of the medicare program.

Senator BENNETT. That is right.

Mr. WICK. And it is very simple. We would be guilty of the violation of our medicare contract upon audit if we put in a cost higher than that which we paid. It is as simple as that. The answer to your question is, we cannot take that profit under medicare, we must charge our cost.

Senator BENNETT. Well, are you sure? Can you demonstrate that you didn't buy one or two at $8.40 to set the cost and then buy the others at a little less?

Mr. WICK. Absolutely, sir. We try to operate within the rules. Very frankly, we feel that the medicare auditing arms are almost overzealous. We have enough difficulty in sustaining charges that we think there can be no question about that certainly are within matters of allocations and that kind of thing.

So I would state that under medicare regulations the audits and the intermediary's activities, barring fraud or barring actionable bad faith, everything is on the record.

I would like to urge, in view of this very unfortunate turn here, that you gentlemen are seeking to find out what will work, and I respectfully suggest that you give us in your colloquy, the opportunity of turning the coin around from the abuses, which we deplore, and certainly should be vigorously monitored to determine with self-dealing, without the opprobrius connotation similar to the automobile operation, similar to buying Western Auto's and that kind of thing. Senator, you have been in the automobile business and I am sure you have seen the vertical system that has become the manner by which standardization has arrived on the scene and a more cost effective product arrived to the public?

Senator BENNETT. I also happen to know if an automobile company is interested in subleting its order for headlights it is about the toughest buyer in the world in terms of securing bids and proposals from every potential supplier of headlights: and if it figures that it can produce the headlights cheaper than the lowest price it gets it produces them in-house.

Now, that is not the kind of situation you face here.

Mr. WICK. No, sir.

However, I would suggest you analyze and make your own determination that with volume and some integration of these services can the large providers provide the total health care delivery of services at a lower price by taking economies of scale and again, I deplore fraud, and I think that the remedies are available.

Senator BENNETT. I would like to stop you at that point and ask you a question.

Mr. WICK. Yes, sir.

Senator BENNETT. You have a related situation in which you have an extended care service, and you have a drug supply house. You buy the drugs at the wholesale price, Don't you sell them to the health

care part of the combination at the same price that they could buy them? Are you required under the medicare law, because you have a related drug supply house, to transfer the drug to the extended care service at your costs rather than at the standard price that is available from the ordinary wholesaler?

Mr. Wick. The rule there, Senator, is—by the way we don't do that and we would like to if it can benefit the program.

Senator Bennett. You don't do what?

Mr. Wick. We have a pharmacy company, we acquired a chain of discount stores in 40 States or rather in 40 cities operating Gibson Discount Stores. We do not sell our nursing homes these prescriptions although we are seeking a way to accomplish it efficiently.

But under the medicare law, sir, one who has a related service, for example, a pharmacy, may charge the medicare program only his costs related to providing the drugs in this particular instance and not the retail charges unless his pharmacy company, which is supplying this, a drug in this instance, ancillary service, does a substantial outside business in that community and the charges are within the norm. Those are the monitoring devices.

Senator Bennett. Doesn't your chain of discount drugs do a substantial business in the community?

Mr. Wick. No, sir.

Unfortunately, the cities where they operate are not in the same cities where we have nursing homes, and so there isn't a large enough volume to make it economical.

Senator Bennett. You have answered me backwards. You do do business with the public?

Mr. Wick. Pardon me.

Senator Bennett. You do do business with the public?

Mr. Wick. Yes, sir.

Senator Bennett. You don't do business with your nursing homes?

Mr. Wick. That is right.

It isn't economic unless we do have substantial business.

Senator Bennett. I would like to ask these other men. Are there any combination nursing homes or extended care facilities that also have drug affiliates?

Mr. Bennett. It has often been talked about, Senator, that a natural adjunct of nursing home care could be install a pharmacy in a nursing home. We know that under 200 beds would be uneconomical but under the medicare program if you have a pharmacy in your nursing home you can only charge whatever your acquisition cost is for that drug to the medicare program. So instead of doing this, prices are raised because the nursing home goes to outside pharmacies and their costs are related to their regular retail price. There is no incentive for a nursing home to supply their own drugs. To answer your question, there are not many homes that do that.

Senator Bennett. In the context of the testimony today I had assumed that you had conglomerates—not a retail pharmacy inside an individual nursing home—but the kind of a situation Mr. Wick talked about where the conglomerate owned a pharmacy or a source of drugs and supplied nursing homes. Have I misunderstood the testimony?

Mr. Bennett. I would like to clarify a term, if I may. The word

conglomerate, I am not sure applies to our people. They are vertically integrated, yes, but as far as being conglomerates I am not sure this is exactly true.

Senator BENNETT. Well, are you horizontally integrated in any sense with suppliers of services which the nursing home has to buy, and which obviously are not generated inside the home?

Mr. BENNETT. Yes, a few companies do have some ancillary companies, and I have the statistics here if you would like them, but it is really incidental to the total amount of their business. And they sell at cost, of course, just as you heard yesterday in the testimony of Medicenters that they build nursing homes and they depreciated them at their cost. The same is true with us. We have to do the same thing.

Senator BENNETT. All right.

I have no further questions.

Senator WILLIAMS. Just a question of Mr. Bennett here. Is the Four Seasons Nursing Home chain a part of your organization?

Mr. BENNETT. Yes, sir, it is.

Senator WILLIAMS. Are they on your board of directors?

Mr. BENNETT. We have a member on our board, yes, sir.

Senator WILLIAMS. Mr. Bennett, you organized the National Council of Health Care Facilities or had something to do with that, did you not?

Mr. BENNETT. No, sir.

I didn't have anything to do with organizing it. I was hired in October 1969. The original planning on this was done in July of 1969, up until that time by a number of the companies who were interested in forming their own organization.

Senator WILLIAMS. When you were about to start your job with the National Council of Health Care Facilities was a contract negotiated between you and Mr. Hutson?

Mr. BENNETT. Between Mr. Hutson, the board and myself, yes.

Senator WILLIAMS. And his foundation?

Mr. BENNETT. I beg your pardon?

Senator WILLIAMS. Did you have a contract with his foundation negotiated at the same time?

Mr. BENNETT. No, sir.

Senator WILLIAMS. No contract at all?

Mr. BENNETT. I am not familiar with the foundation.

Senator WILLIAMS. I am speaking of the Americana Foundation. No contract at all?

Mr. BENNETT. No, sir.

Unless somebody has found some papers in my office that say foundation on them or something.

Mr. WICK. Am I out of order if I ask a question?

Senator WILLIAMS. What did you mean by that latter statement?

Senator BENNETT. Does that mean the committee has been digging around papers in your office?

Mr. HUTSON. I might clarify that point, I am an officer of the Americana Foundation, which has no nefarious purposes or any side deals or any reason for existence——

Senator WILLIAMS. I didn't suggest it did.

Mr. HUTSON. Except if it works. The Americana Foundation's articles of incorporation and bylaws were used as a model for the national council. I don't believe Mr. Bennett knew that, but there has been no connection at all between the foundation and the council.

Senator WILLIAMS. That was my understanding, too. Since the question has come up, perhaps you can tell us what the Americana Foundation does?

Mr. HUTSON. Well, basically it is involved in scholarships to people in the health care industry to provide more skilled people in the health care industry. It has made a study of a not-for-profit nursing home extended care facility addition on to a community hospital and helped in the formation and financing of that. It is working with a group on a housing project, again on a non-profit basis.

Senator WILLIAMS. How many scholarships have they approved so far?

Mr. HUTSON. I wouldn't know. It is a fairly small number, it is not a very large foundation and it would be 30 or 40, fairly small scholarships, there are LPN training, RN training, some physiotherapeutists.

Senator WILLIAMS. That is all.

Senator RIBICOFF. Thank you gentlemen.

(Mr. Bennett's prepared statement follows:)

PREPARED STATEMENT OF BERKELEY V. BENNETT

I am Berkeley V. Bennett, executive vice president of the National Council of Health Care Services. On my right is Keith E. Hutson, president and chairman of the board of Americana Nursing Centers, a large privately held multifacility company headquartered in Monticello, Ill. Mr. Hutson, who is a lawyer, is widely regarded, both within the industry and outside it, as an expert in the extended care portion of the medicare program. He has been involved in the industry for 10 years—since 1960 when he founded Americana Nursing Centers, in an attempt to meet the growing need for high quality health care facilities.

Since medicare was enacted, Mr. Hutson has traveled throughout the country, studying the program's problems and potential solutions. He is also active in the American Nursing Home Association, where he is chairman of its multi-facility conference, a member of its legislative committee, and serves on its executive board. On my left is Charles Z. Wick, president of United Convalescent Hospitals, headquartered in Los Angeles, Calif. Mr. Wick has been in the industry since 1961, when he formed United Convalescent Hospitals after several years of research to provide top quality nursing care for a relative. The publicly held company presently operates 20 extended care facilities in 9 States. Mr. Wick, a lawyer, was appointed to President Johnson's Task Force on Nursing Homes and Related Facilities in 1966. He is a member of the American Hospital Association's type II governing council and serves as a delegate-at-large. He is also a former chairman of the ECF conference of the American Nursing Home Association.

For the past 25 years, my experience has been concentrated in health related industries and association management with emphasis in the nursing home field. I have served as executive director of the New Hampshire Association of Licensed Nursing Homes, the Vermont Pharmaceutical Association, the American Society of Consultant Pharmacists, and the Vermont Nursing Home Association. In this capacity, I personally set up uniform financial records for some 60 nursing homes in Vermont. In a recent essay on "Nursing Home Standards—A Tragic Dilemma in American Health", Jordan Braveman reports:

"Another glaring licensure deficiency pertains to the whole area of health costs. At a time when the costs of health care, generally, and the costs of the Medicare program, in particular, are escalating rapidly throughout the Nation; at a time when the determination of reasonableness of health care costs is in question and difficult to determine; at a time when there is a lack of uniformity among the accounting procedures of nursing homes, only one State, Vermont,

has made it a licensure requirement for nursing homes to maintain uniform cost records as prescribed by the State Licensing Agency. Whether the regulation is able to achieve its desired goals depends upon those involved in the program, but, thus far, only one State in the country through law has attempted to bring fiscal order out of financial chaos."

I was responsible for this step and therefore would like the committee to understand my long-time concern with costs and with good management. In addition, I have served as nursing home consultant to Johnson & Johnson, and the National Wholesale Druggists Association, and presently am on the editorial board of Modern Nursing Homes magazine. I am a member of the Small Business Administration's (Vermont) Advisory Council and have been appointed to the U.S. Public Health Service's Task Force on Health Administration.

The National Council of Health Care Services, organized in October 1969, is an association of multifacility nursing facilities representing major companies in the industry with an aggregate estimated investment of $550 million. Approximately 90 percent of the council's member companies are publicly held. Public companies must come under closer scrutiny than the sole proprietorship and partnership.

As a condition of membership, each company in the council owns and operates at least three nursing home facilities with a minimum of 300 certifiable beds. All told, council members provide close to 70,000 licensed beds. Members of the National Council of Health Care Services are united in a common objective: to promote and maintain a professionally and economically sound health care program, with emphasis on providing the best possible care for the patient at the lowest possible cost.

Our members recognize that their first obligation is to the patient, and any health care facility that fails to show proper concern for the patient's welfare does not deserve to stay in business.

Further, there is nothing immoral about profit motivating people to provide the best service for the money, consistent with the patient's best interest. Lower cost does not necessarliy mean lower quality of patient care. Because multifacility nursing homes are in the competitive market, it means they must offer true value for the services performed. To quote from David A. Jones, secretary-treasurer of the council and chairman of Extendicare, Louisville, Ky., with 60 nursing centers and 13 hospitals.

"The multifacility concept of operating nursing homes has brought significant improvement in the quality of medical care available to many Americans. This movement will continue in the years ahead, raising the standards of care available in nursing homes.

"The new trend is most readily apparent in the modern nursing centers operated by the multifacility companies, but it goes deeper than the physical plant. High standards of care and efficiencies in management are important parts of the picture.

"By being able to spread the cost among several nursing centers, multifacility companies are able to hire highly qualified staff specialists to assist individual nursing homes in delivering high-quality care.

"The combination of high standards of care in a modern setting, backed by the efficiencies of professional management will create a continuing future demand for more nursing homes operated by the multifacility companies."

We will be using passages from the excellent Senate Finance Committee Staff Report as the basis of our presentation before the committee today

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"The dovetailed information which the staff has collected and developed indicates clearly that the utilization review requirements have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The present situation has been aptly described by a State medical society in these words: 'Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token."

The council feels strongly that there must be teeth in the utilization review regulations and just as importantly that there be incentives for the patient and the physician to seek the proper level of care. Mr. Hutson will discuss this in

detail. A council member, Paul Sukernek, president of the National Nursing Home Development with five facilities in three States, States in a letter: extract follows:

NATIONAL NURSING HOME DEVELOPMENT CORP.,
Pittsburgh, Pa.

An open letter to members of the Senate Committee on Finance:

DEAR COMMITTEE MEMBER: We in the nursing home field are suffering low occupancy while the hospitals are overcrowded with people over 65 years of age who could be better cared for in nursing homes at one quarter of the cost to the government.

I cannot help but feel that this is a great big administrative error that has taken place in an effort to reduce the cost of the medicare program. Apparently someone thought that it was easier to attack the problem at the low cost level rather than the high. This is not the business way to do it, obviously. I do not believe anyone in government would let his wife make an $80 purchase when there is a sufficient item at $20; nor would anyone in government suggest at home that in order to reduce expenditures that they buy steak instead of hamburger, or purchase a Cadillac instead of a Ford.

Endless millions of medicare funds are being wasted as a result of this administrative error. Doctors in the cities where we operate have told us time and again that 50 to 70 percent of the over-65 hospitalized patients could be better cared for in our extended care facilities, but they dare not transfer them because they will lose their Medicare coverage.

Very truly yours,

NATIONAL NURSING HOME DEVELOPMENT CORP.,
PAUL SUKERNEK, *President.*

Utilization review must also apply to other levels of care as well. The patient should remain in the proper facility only that length of time that he requires that level of care.

To continue with the staff comment on page 135, Mr. Wick will not discuss specific areas of management.

I am Charles Wick, president of United Convalescent Hospitals in Los Angeles, Calif. I will be discussing two related matters today—the role of multifacility operations in the provision of health care facilities and services, and the related issue of stock prices of publicly held companies.

The so-called "chain nursing operations" offer the optimum hope to Government, beneficiaries and taxpayers for uniform excellent in health care at the lowest possible price.

In our Nation, free enterprise has traditionally answered great challenges, and answered them well. During World War II when the Government was faced with Franklin Roosevelt's vow to build 50,000 airplanes in 1 year, it turned to private industry. It was the "free enterprise system," marshalling its resources, directed toward the goal of producing more airplanes, that accomplished that task. Similarly, when the Japanese cut off our supply of natural rubber from Malaya during World War II and the synthetic rubber industry had to be built overnight, again it was the attraction to this task of a variety of brains and disciplines wedded to free enterprise systems that produced the response to the problem.

The public company "chains" are dedicated to the proposition that in a free enterprise system, they have no basis for remaining solvent unless they can respond to a public need in a cost-effective manner—providing the highest quality at the lowest possible price.

Historically, the nursing home—ECF business has been controlled by the "mom and pop" operations. The individual entrepreneur, tending his own business, had to wear a multitude of hats in providing health care services to his patients. Many of these people have been undeniably well motivated and have done a fine job. However, the uniform quality and availability of health care services they have been able to provide has proved to be inadequate.

In the evolution of every new industry, the first steps have been taken by the small experimenters, or, in his case, by the "mom and pop" operators. As the volume of the product or service increased and the product became more uniform and better qualitatively, the managers were rewarded, as were their employers and corporations as a by-product of providing a superior response to a vital need. The multifacility operators approached the problem of providing cost-effective

quality health care services in the traditional manner of free enterprise. In the nursing homes, or ECF's, services provided range widely across the spectrum of individual disciplines, including housekeeping, nursing and dietary supplies, institutional feeding techniques, accounting, drug control, and management. Multi-facility companies have sought to marshall the best talent in the various disciplines that comprise health care services through the medium of profit-sharing and stock options, which would reflect their success in providing the public with high quality, lower cost health care services.

Major improvements in the quality of health care services, as in other areas, must result from employment of modern, highly developed management techniques and a systems approach to ensure uniformity in the quality of services. Cost-reduction can occur only when this approach is used. To cite the House Committee on Ways and Means (p. 46) :

"Your committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their operations. The fact must be faced that deficiencies in hospital management owe something, at least to inattenton, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital trustee, or a hospital should be."

PERSONNEL

Nursing services, which are responsible for two-thirds of the labor costs, can be upgraded in degree and kind—not through new technology, but through training aids and techniques which can only be provided by specialists in training. With the "mom and pop" development of nursing homes disappearing, because of tight money; with long-term lenders now looking toward a substantial net worth mortgagor as further security for their loans, the "mom and pop" operations are unable to compete with the larger organizations in attracting qualified personnel. Further, the small operator cannot afford the cost of proper training, when spread over only a single unit.

As the automobile industry evolved into a large volume operation, it was forced to adopt mass training procedures for people who had never been in the automobile industry before. Other industries have responded in the same manner—and so must the health care industry respond. The publicly owned multi-facility companies are in the best possible position to accomplish this.

UNIFORM FINANCIAL REPORTING AND CONTROL

Inherent in the cost effectiveness of any business are substantive, timely, and uniform statistical and financial reporting and controls. Computers, available only to a large volume multifacility company, provide the most detailed types of timely statistics which can be used as a control technique for inventory and cost. Computers can also be used to develop uniform financial accounting systems.

CONSTRUCTION, DESIGN, EFFICIENCY

Health care facilities can be built less expensively and designed for greater efficiency of operation when construction and design reflect previous experience and utilize methods of mass production. Knowledge, through experience, of functional aspects, such as positioning of nursing stations, is a decisive factor in the efficiency of personnel in the performance of a particular task.

PUBLIC VS. PRIVATE SECTOR

How does Government usually answer when addressing itself to a public need? It does not enter into the airline business or the trucking business to fulfill transportation requirements. It looks instead to private enterprise—mainly the large scale, management-oriented sector.

The multi-facility companies are comparable to other big business, which uses volume as a lever to organize the random ingredients which make up the finished product in a highly cost-effective manner, to the ultimate benefit of the consumer. Its criteria for success must be to give the consumer the best product and/or service at the most effective price. When this is done in an arena where competitors seek to perform the same function, the public obviously must be the beneficiary. The motel and hotel chains have replaced the early "mom and pop"

operations by attracting layers of management from complementary disciplines and utilizing a systems approach designed to provide the maximum uniformity of services to the public. The public has responded by recognizing that these chains are providing the best value for the dollar and the most predictably consistent quality.

PROVISION OF ANCILLARY SERVICES

Senator John J. Williams is quoted in the Staff Report on Page 135, as follows: ". . . Furthermore, if a chain owns an extended care facility as well as a hospital it can see that patients go from its hospital to its nursing home. A chain may also own pharmacies or sell hospital supplies to a readymade captive market in its hospitals and nursing homes at a high non-competitive price."

Any concern, that the so-called chains are involved in conflict of interest or areas antithetical to the best interests of the public because they also have ancillary companies which provide drugs and other services, is to confuse abuse with a meritorious system. The ECF is really a broker for a myriad of services, such as nursing care, housekeeping, nursing supplies, dietary provisions, insurance, etc. If a multi-facility corporation can provide these services from within its own affiliated companies, obviously it can avoid duplication of overheads from various suppliers. It can supply these individual ancillary services at a lower margin than might otherwise be possible, since it delivers these services to one central place it controls.

In the area of purchasing supplies, we know that similar homes have similar needs and purchasing requirements can be fairly well standardized. Through mass purchasing the lowest price can be obtained. This leverage makes it possible to buy high quality items at the right price. One example, in purchasing patient vests a local distributor's list price is $8.40 each. By buying through centralized purchasing, the price is $5.85 delivered, or a saving to the patient or third party payor, of $2.10 each. It is certainly not unusual that in one city, there will be a number of hospitals and nursing homes all buying similar items, who should work together to disclose their sources of supply and prices paid, so that they can concentrate their purchases. The savings could be monumental. Simple comparisons of this type on a timely basis would put relevant information in the hands of those that could best help reduce the cost of health care. There are other advantages relating to professional evaluation of products: time saved in interviewing salesmen; savings in nurse's time; and savings in storage through drop shipments.

With the opportunity to make a relatively small profit on a group of components of total health care system, the public company can provide its investors and its managers with suitable rewards—made possible only by providing superior cost-effective quality to the public, the Government, and all others involved.

ABUSES

Those public companies which will survive must, and do, deplore abuses by providers. Realizing that their very survival is inescapably interwoven with provision of high quality health care at a reasonable cost to the taxpayer, the well-motivated companies will be quick to assist the Government in detection and reporting of abuses—especially in those areas where knowledge of the health care field is necessary for early detection. The highly-motivated companies must fear abuses as being inimical to their own survival.

HEALTH CARE STOCK PRICES

The glamor of nursing home stocks, some of which have been sold at inflated values, is a thing of the past. Some of these stocks are now as much as ninety per cent off their highs. Many stocks in the health care industry are now selling well below their book value. Very few of the multi-facility companies are making any profits in the nursing home field. Current market conditions have further depressed this segment of the market.

Nevertheless, the increased number of dollars that an investor-speculator is willing to pay for shares of stock does not increase the cost of care to the beneficiaries, or the Government. Whether the airline stocks go up or down, the quotation of the stock's value has little impact upon the competitive prices that the public is charged or is willing to pay. Similarly, the public company sector of the nursing home field recognizes that the ultimate value of its stocks can only be measured by the amount of profits it can make for its investors as a

return on investment. Those profits in the future can only reflect the fulfilling of a need in an effective manner, pleasing to the public and superior to competitors.

The shrinkage in Medicare payments caused by retroactive denials and other uncertainties which cause physicians to keep elderly patients in hospitals longer have created a severe disenchantment on the part of managers of multi-facility, publicly-held nursing home companies. The dilemma has become more acute in those instances where Medicaid also does not pay adequately.

While tight money obviously is an impediment to further proliferation, it is no longer a major factor in the abandonment of further development of nursing homes. The key factor is, instead, the existing uncertainty regarding Government regulations for Medicare and Medicaid.

United Convalescent Hospitals, of which I am President, recognized the severity of this problem in July 1969. We abandoned all foreseeable future development and wrote off almost a million dollars in costs, rather than proceed with building additional ECFs in the face of great uncertainty—not only regarding future profits, but also whether even our costs could be recovered.

SURVIVAL

There have been assertions that public health care companies are in the midst of a bonanza. To the contrary, many of them are on the verge of going broke. Medicare and Medicaid are not reimbursing them for their true costs and profits are non-existent.

The buildings and systems and people controlled by these companies represent an investment of hundreds of millions of privately raised dollars. If the Government does not seriously, soberly, and immediately appraise this situation, there is a very real possibility that thousands of beds may have to close down.

Where will the patients who should fill those beds go? Who will provide the hundreds of millions of dollars necessary to replace them? If the free enterprise, multifacility sector does not (because it cannot) provide the capital and the talent pool to develop and operate nursing homes in the future to meet the ever-growing need, then it will fall upon the Government and the taxpayer to provide the risk capital.

My name is Keith Hutson. I am President of Americana Nursing Centers, which operates 36 extended care facilities, with over 3,000 beds, in Illinois, Indiana, Iowa, Nebraska, North Dakota, South Dakota, Wisconsin, Minnesota and Florida.

As President of the National Council, I have compiled a rather extensive treatise on Medicare's institutional care programs. We strongly suggest sweeping reforms in the principles under which these programs are administered. To date, most of our effort has been directed to Medicare problems. Medicaid problems are now coming to the fore. They too can be traced largely to unworkable principles. In the near future the Council will have detailed suggestions for Medicaid reform. The two programs have much in common.

These Medicare suggestions are entitled "The Case of Incentives" and are summarized in a one-page printed sheet which you have in your folders from the Council. They are dealt with more completely in the blue booklet with the same title, which also can be found in your folder.

To conserve time at this hearing, may I merely outline this "Case for Incentives", and suggest that detailed study of our materials, and staff consultation with the Council, will be helpful in the huge task the Committee has, in making Medicare what it was originally intended to be: a workable program for the benefit of the elderly ill citizen.

THE CASE FOR INCENTIVES

A. *Introduction.*—Medicare costs are skyrocketing, primarily because the present program principles encourage over-utilization of health care resources, and discourage efficiency.

B. *Best Combination of Quality and Cost.*—How can Medicare encourage physicians and patients to seek, and providers to provide, health care which is the best combination of quality and cost? By operating under principles most likely to:

1. Discourage over-utilization of health care resources;
2. Discourage selection of expensive facilities at excessive cost to government;
3. Encourage providers to be efficient; and
4. Encourage simplicity of administration.

C. *How to keep quality high.*—Rely upon present incentives and controls:
1. Natural incentives for quality—for consumer, provider, professionals.
2. Back-stop controls—high standards, uniformly enforced; adequate payments.

D. *How to keep costs down.*—here's where the principles need a total overhaul.
1. Natural incentives for economy:

(*a*) *Incentive to provider* is maximized by prospective rates. To encourage provider efficiency, and to simplify administration, Medicare payments should be related to charges, not costs. Rates should be established prospectively by each provider, with Medicare ceilings (see 2d below) also established prospectively.

(*b*) *Incentive to consumer* is possible only when he has a stake in the costs of his care. To maximize incentive, the present flat rate deductible should be replaced with a percentage-type co-insurance. To be most effective, the Medicare share should be as low as possible (recommendation—80%). Co-insurance should start on the earliest possible day, and apply to all possible charges (See 2a below as to indigent patients).

2. Back Stop Controls:

(*a*) *Dis-incentive to over-utilization by medically indigent patient.* The patient who is unable to pay for a subtantial share of his care should be helped in two ways: the government should (i) pay for his care, and (ii) help him exercise proper judgment in making the necessary selections.

(*b*) *Dis-incentive to over-utilization by physician*—physicians should make decisions on utilization, and be accountable for abuse.

(*c*) *Reduce covered days* to thirty hospital and sixty in ECF. with additional days available for catastrophic illness or a new spell of illness.

(*d*) *Medicare ceilings* should be established, to guard against the failure of natural controls to maintain reasonable rate ceilings. It is recommended that the average daily Medicare ceiling for covered charges in an ECF should be established prospectively for each year, as ¾ of 1% of the area's per capita income figure, as tabulated by the U.S. Government for the latest available prior year.

(*e*) *Access to the court or arbitration* should be readily available to provider, payor and patient.

E. *Summary* of most important recommendations: Medicare payment should be limited to 80% of the provider's established charges for covered services, up to a daily ceiling of ¾ of 1% of the area's annual per capita income, with the beneficiary paying the balance. If he is medically indigent, government must pay the balance, and participate in decisions that affect cost. Physicians should make medical judgments, and be accountable for abuse of their authority.

PAGE 39—COMMITTEE ON WAYS AND MEANS REPORT

"The reduction in matching funds for skilled nursing homes is directed toward early transfer of patients to alternative facilities (such as intermediate care facilities), and the provision granting authority to the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and the cost of intermediate care facilities is designed to assure that supporting care in these alternate institutions results in decreased costs. These provisions reflect the concern that many patients remain in skilled nursing homes longer than necessary and that as a result program costs are unnecessarily increasing."

Medicaid has given the Government and the patient the best health care for the money to date. If the administration's proposals to reduce matching funds one-third after a beneficiary has received ninety days of skilled care are adopted, the program will falter and costs will merely be shifted back to the hospitals and to the ECF program. The elderly ill patient cannot be shunted from facility to facility depending on changes in the programs. Change is anathema to the elderly, and their dignity must be respected. This would not be possible if after ninety days he was shipped out to a lesser cost, lesser staffed institution for the sake of saving a few dollars. This comes at a time when there is a public and congressional outcry for high standards of care. The Council wants the skilled care regulations enforced equally. Effective utilization review and the physician should determine the level of care needed.

PAGE 50—COMMITTEE ON WAYS AND MEANS REPORT

"The reasons for requiring hospitals and extended care facilities to have utilization review committees for Medicare cases applies with equal force to review of Medicaid cases, but there is now no such requirement in the medicaid law."

In conclusion, first, *standards of health care for the elderly must be raised not lowered.* The Council advocates maintaining the present Medicaid program (except in those states not paying enough to receive true skilled care) for one year or until a nationwide care-related program can be established. . . .

Secondly, *there must be a drastic revision in the Medicare program* to define and effectively regulate the *proper utilization of health care facilities.* . . .

Thirdly, there *must be incentives in the programs* for the physician to utilize the proper institution, for the patient to seek the proper level of care and incentives for the provider to efficiently deliver the level of health care needed at the lowest possible cost. . . .

Fourth, the *multi-facility health care companies* or facilities sharing common management methods and services will be the *best equipped to provide the best nursing and ancillary services to patients at the lowest possible costs.* And fifth, there must be a *closer liaison between the Government and the providers* to conscientiously work out practical, workable solutions to problem areas so that the patient can receive the consideration he deserves. The Staff Report states:

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"Patterns of payment and standards of care are related between the programs. A single advisory group would avoid duplicative activity and lend greater focus to and coordination in treating common concerns. A subcommittee approach might be the appropriate method of attending to those areas peculiar to Medicaid."

Senator HARTKE. Dr. Jack Hall is from Indianapolis, Ind. He is connected with the Methodist Hospital there and is one of the progressive movers in the field of hospital administration and generally in the field of medical education. I just wanted to add my special welcome to him to the committee here. I think you will find his information very helpful.

Senator RIBICOFF. Thank you Senator Hartke. I am sure we will. You may proceed, Dr. Hall.

STATEMENT OF DR. JACK HALL, PRESIDENT, ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

Dr. HALL. Thank you very much, Senator Ribicoff. I would like to take this opportunity of thanking Senator Hartke for the introduction. I believe that most of the citizens of Indiana, and I hope a great number of them, appreciate the forward looking and courageous leadership that I believe is the best that our State has ever had in its representation in Washington.

Senator HARTKE. Thank you, Dr. Hall. I didn't expect that this morning, but I appreciate it.

Dr. HALL. I believe it is very true.

I am here today as president of the Association for Hospital Medical Education. On my right is Mr. Ted Kummer, executive director of the association. We represent about 500 community hospitals that have in their graduate education programs approximately 40 percent of the house officers in training in this country. Our medical staffs provide representation for over 125,000 of the practicing physicians in this country, giving them an opportunity to participate in the service of education.

Community hospitals, as a rule, have received little or no Federal support for educational activities. In spite of this they have provided an opportunity for educational programs that prepare physicians to deliver health care services in our country.

This has been accomplished by a system of levying the charges for services rendered to the patient receiving the services, or establishing the patient as a center of the costs for services rendered.

The segments of the health education community that have not followed this pattern have been primarily responsible for the problems that we are discussing here today in medicare and medicaid. We are not aware of any abuse of the present program for reimbursements by members of our organization. It is important to emphasize that 95 percent of the teaching in our programs, the programs that our members represent, function on a voluntary basis without direct financial reimbursement.

We believe it is critical that careful consideration be given to any changes that may affect the significant voluntary effort in education.

The problem—and I am trying to summarize—as we see it, lies in one area. The three forms of reimbursement for teaching physicians under medicare are: One, fee for service reimbursement for care rendered to "private patients" under part B of the Medicare Act. We accept the committee staffs definition of a "private patient" and believe it is one of the best definitions that we have seen.

The second area of reimbursement which is under part A is for full-time hospital staffs who often perform both teaching and patient care service functions for the "institutional patient" which is in contrast to the "private patient."

Third, reimbursement also occurs under part A and under part B for part-time teaching and patient care service for "institutional patients" and it is in this area that we have discussions and oftentimes misunderstandings.

The services rendered to "institutional patients" have usually been rendered by residents and interns in training under the general supervision of the assigned full-time and/or part-time staff doctor, "supervisory physicians." They assume medical and legal responsibility for the care rendered. There have been instances where the care rendered by house staff—residents and interns—to these "institutional patients" who are medicare beneficiaries has been reimbursed under part A which we believe is appropriate, and where reimbursement for the same services has been sought by a supervisory physician under part B, who was also paid under part A. Clearly this is double reimbursement and it is unequivocally wrong.

In an effort to meet the mounting costs for medical education, since the community has not seen fit to assume responsibility for the total cost of medical education, the pressure and concern for payment of "supervisory physicians" for "institutional patients" has been primarily expressed by the teaching hospitals rather than by the physicians themselves. The physicians have gained little or nothing from this reimbursement program.

The Association for Hospital Medical Education recommends a solution where we will eliminate the possibility of dual charges. That is reimbursement for teaching service patients must be unified either under part A or under part B or a unified combination of the two to prevent the aforementioned dual charges.

We recommend that this reimbursement be made only under part A which we believe is the least complicated alternative. It will eliminate fee-for-service reimbursement under part B for care rendered to "institutional patients" who are medicare beneficiaries.

In nearly all community teaching hospitals the majority of the teaching responsibilities have been met in the past on a voluntary basis, without regard for reimbursement.

However, today the increasing demands for the physicians' time and the complexity of contemporary medical education threaten the continuation of this process. It is important that we develop a mechanism that will continue the important education and charity service that is rendered in this voluntary manner by physicians.

A mechanism for part-time payment for the management of teaching service patients or "institutional patients" should be developed through part-time arrangements between the teaching physicians and the hospitals, reimbursing the teaching physician on a salary-equivalency basis, the cost of which should be reimbursable to the institution under part A.

Salary-equivalency should be based on the average salary for the full-time physicians in that institution or in like institutions in the area.

This should not preclude the usual and customary fee-for-service reimbursement to the physician who is teaching under part B for other medicare beneficiaries who are really bona fide "private patients."

We recommend further that because there is inadequate knowledge relative to the proportion of effort devoted by part-time voluntary teaching physicians to teaching and patient care services and part of our present dilemma is our inability to quantify this effort, there should be studies funded for task analysis, cost analysis of performing the tasks and determination of the most cost-effective apportionment for third party reimbursement. I hope that within the law there will be room for the development of such pilot programs which will act as guides in our future deliberations for changes in the law.

One additional point needs to be stated although it may not be particularly relevant to the issue of reimbursement. We are worried that some of our physicians, reading only the headlines that may come out primarily in the medical news, may have the impression that if they include their "private patients" for intern and resident education, and have an active part in the management team in the care of these private patients, that they will not be able to receive reimbursements under part B for their service, and thus it would significantly hamper and increase greatly the cost of medical education and medical services to these "institutional patients." Thus we hope that, in any amendment to the Medicare or Medicaid Act, there will be a statement that will avoid any misinterpretation. We hope that you will put in this law a statement that states that it is common and appropriate practice that interns and residents participate actively in the management of "private patients" with their attending physicians. This should not interfere with these physicians rendering statements under part B of the Medicare Act.

I thank you very much, Mr. Chairman.

Senator Ribicoff. Thank you.

Doctor, what tangible and professional benefits does the individual private doctor derive from part-time service as a teaching physician in a hospital?

Dr. HALL. I believe honestly the tangible benefits are almost zero. In general, most of the physicians that choose to do this are outstanding men who have established themselves with respect in the community, have a large practice, and are very, very busy.

In accomplishing the objectives of education it requires time, and time is money to these people. Thus, whether they are having a surgery resident participate actively with him in the removing of a gall bladder or working with him in the case of pericardial infarction, and they are working with that man, it takes more time, but they get a very, very important intangible benefit out of this. They get a stimulus to maintain themselves as excellent physicians that can be gained in no other way. Most of these men are willing to contribute their time for this important stimulus.

Senator RIBICOFF. In other words, it makes them more effective as doctors and surgeons. They have to keep up with the latest methods. It gives them experience in a large variety of cases and also it enhances their reputation as doctors of substance in their community?

Dr. HALL. Very definitely.

Senator RIBICOFF. Don't many hospitals require this part-time service for members of their staff, isn't this a requirement in many hospitals?

Dr. HALL. Yes.

Some hospitals do. I think this gets into somewhat of a problem though. If you make this a requirement of staff membership then you imply that you will use every man on your staff for teaching activity. I personally believe that the hospital is an organ of the community, it is a representative of the community, and all physicians that are rendering good health care should be related to that health care delivery organ, the hospital in the community. But not all physicians are good teachers, and we should then restrict our house officers' relationships to those who are most effective teachers because time again is valuable both for the teacher and the student, and so I do not feel that the requirement of the hospital for the physician to teach automatically makes him a good teacher. It sometimes acts as an inhibition for good teaching within the institution.

Senator RIBICOFF. Of course, I would assume that the staff of a hospital, and the hospital administrators, are aware of that and the requirements do take that into account accordgly, isn't that right?

Dr. HALL. Sometimes—I represent a large institution of well over 1,200 beds as director of education, and we have over 700 physicians on our staff. They all have access to bring their patients to our hospital and render care to them there. They agree that they will render care by stanards that they all review, by criteria of review, but not all of them are good teachers and I only want to use the good teachers.

Therefore, I guess I am talking around your point, but I do not feel that making this a requirement of the staff necessarily assures this physician of any advantage or assures the house officer of getting good people.

Senator RIBICOFF. I am not saying that, but aren't there hospitals that do require this of members of their staff?

Dr. HALL. Yes, sir.

Senator RIBICOFF. Whether it is a good policy or a bad policy isn't the problem. But don't some hospitals require that?

Dr. HALL. Yes, they do. This is more often in the eastern and far western hospitals in which closed medical staffs are common policies.

Senator RIBICOFF. In general, do medical school faculty members serving as part-time physicians in hospital centers function differently in terms of institutional patient care than those teaching physicians in the hospital you represent, your own hospital?

Dr. HALL. Relative to "institutional patient" care?

I do not believe so. I believe that both assume a responsibility for the patient, they must identify with that patient and must review it if they are going to fulfill that responsibility well. I am proud of the excellent job the men do in our institution. I know at times that I have participated actively in teaching at the university. I have tried to render the same type of service as with our hospital institution.

Senator RIBICOFF. Do you agree with the committee staff that the direct involvement of the teaching physician with a given institutional patient's care may range from nil to extensive?

Dr. HALL. Yes, I do. I would have to ask you to qualify nothing but I am sure examples can be found where there have been no direct identifiable services rendered to institutional patients by the members of the staff that are active in the education program.

Senator RIBICOFF. Senator Williams.

Senator WILLIAMS. No questions.

Senator BENNETT. Mr. Chairman, I have a question. On pages 4 and 5 you say hospitals be compensated for voluntary medical staff time on a "salary equivalency" basis. Isn't that similar to the basis of payment to hospitals for the services of nurses who as members of religious orders have taken vows of poverty?

Dr. HALL. Yes, Senator, that is. It may be that we will go back and contract with these physicians for their time and reimburse them or use it in other elements of the education program.

I do hope that the funds so available to the hospital will be under the control of the teaching faculty so that they can disburse it in the most appropriate educational manner.

Senator BENNETT. Is this salary-equivalency proposal consistent with the new team approach of teaching in the hospital?

Dr. HALL. Yes, I believe so.

Senator BENNETT. Under this program medicare would pay the hospital its proportionate share of such costs, is that true?

Dr. HALL. Yes, sir.

Senator BENNETT. The last question I think you have already answered indirectly. Are any of your members connected with hospital centers operated by medical schools?

Dr. HALL. Yes, sir.

Senator BENNETT. That is all. Thank you.

Senator RIBICOFF. Senator Hartke?

Senator HARTKE. Just a comment. I think the staff has indicated to me that you were working with them very closely and have come up with an idea which basically has a great deal of merit and which they feel is going to be extremely helpful.

I want to thank you again for appearing here, and I think on behalf of the committee I want to thank you for the work you contributed in trying to make this a successful program.

Dr. Hall. Thank you very much.

Senator Ribicoff. Will you gentlemen please remain so that the staff may ask some questions.

(Dr. Hall's prepared statement follows:)

Prepared Statement of the Association for Hospital Medical Education, Presented by Jack H. Hall, M.D., President

Mr. Chairman, Senators, ladies and gentlemen. I am Dr. Jack Hall, President of the Association for Hospital Medical Education. On behalf of the membership of the Association may I say that we appreciate this opportnuity to comment today on the important topic of reimbursement or compensation for teaching physicians in the community teaching hospital.

AHME REPRESENTATION

Through its membership, the Association for Hospital Medical Education represents the medical educational programs in approximately 500 community hospitals. The hospitals are fairly large, averaging about 450 beds. The hospital where I work, for example, is now over 1200 beds in size.

These hospitals have in their graduate education programs—intern and resident training—approximately 40% of the intern and resident training positions. Over 125,000 practicing physicians in the United States belong or relate to the medical staffs of these hospitals—community hospitals with approved graduate education programs.

Community hospitals, as a rule, have received little or no federal support for educational activities through programs of the National Institutes of Health and other like federal programs. In spite of this, they continue to provide an opportunity for educational programs and they well prepare physicians to deliver health services in our country. This has been accomplished essentially through a system of levying the charges for services rendered to the patient recipient. The segments of the medical educational community that have not followed this pattern have been primarily responsible for the problem that we are discussing today. We are not aware of abuse of the present plan for reimbursement by members of our organization. It is important to emphasize that 95% of the teaching in the programs of our members function on a voluntary basis without direct financial reimbursement. Therefore, alterations that effect all programs must be carefully considered from the standpoint of their effect on the important role of the voluntary teacher of medicine in community hospitals.

THE PROBLEM

What is the problem? As you are well aware, the three primary forms of reimbursement for teaching physicians under Medicare are:

1. Fee-for-service reimbursement under Part B for service rendered to "private patients"—ordinarily patients who were seen by the physician in his office prior to hospital admission; for whom the physician arranged admission to the hospital; who were visited and treated by the physician during their hospital stay; who would ordinarily turn to him for follow-up care after discharge from the hospital; and who are legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of charges is routinely and regularly sought by the physician.[1] (You will recognize this definition as that described by this Committee's staff. It is probably the best and most comprehensive definition of the "private patient" that we have seen.)

2. Institutional reimbursement under Part A for full-time hospital staff performing both teaching and patient care service functions for "institutional patients"—those patients that have ordinarily presented themselves to the institution for treatment.

3. Reimbursement under either Part A or Part B for part-time teaching and patient care service activity for "institutional patients".

[1] "Medicare and Medicaid—Problems, Issues, and Alternatives", Report of the Staff to the Committee on Finance, United States Senate, February 9, 1970.

Items one and two above have presented no problem from a reimbursement-for-teaching point of view because there has been no dual opportunity for reimbursement for services rendered to "institutional patients" who are Medicare beneficiaries.

The problem lies in item three. The services rendered to "institutional patients" have usually been rendered by residents and interns in training under the general supervision of the assigned full-time and/or part-time staff doctor, "supervisory physician", who assumes the medical and legal responsibility for the care rendered. There have been instances where the care rendered by house staff—residents and interns—to these "institutional patients" who are Medicare beneficiaries has been reimbursed under Part A (a proper procedure), and where reimbursement for the same service has been sought by the "supervisory physician" under Part B. Clearly, this double reimbursement is unequivocally wrong.

In an effort to meet the mounting costs for medical education, since the community has not seen fit to assume responsibility for the *total* cost of medical education, the pressure and concern for payment of "supervisory physicians" for "institutional patients" has been primarily generated by the teaching hopsitals rather than by the physicians themselves, to gain reimbursement for the physicians' efforts.

RECOMMENDED SOLUTION

To eliminate the possibility of dual charges, reimbursement for the teaching service patient ("institutional patient") must be unified—either under Part A only, under Part B only, or a unified combination of the two. The Association for Hospital Medical Education recommends that this reimbursement be made only under Part A, the least complicated alternative, thereby eliminating a fee-for-service reimbursement under Part B for care rendered to the teaching service patient ("institutional patient") who is a Medicare beneficiary.

In nearly all community teaching hospitals the majority of the teaching responsibilities have been met in the past on a voluntary basis, without regard for reimbursement. Increasing demands for the physicians' time and the complexity of contemporary medical education threaten the continuation of this process. It is important that a mechanism be developed that continues this important education and charity service that is volunteered by physicians. A mechanism for part-time payment for the management of teaching service patients ("institutional patients") should be developed through part-time arrangements between teaching physicians and hospitals, reimbursing the teaching physicians on a salary-equivalency basis, the cost of which should be reimbursable to the institution under Part A. Salary equivalency should be based upon the average salary for full-time physicians in that institution or in like institutions in the area. This should not preclude the usual and customary fee-for-service reimbursement to the teaching physician under Part B for other Medicare beneficiaries who are bona fide "private patients".

We further recommend, that provision be made in the Medicare Act amendments for exploration of alternatives to the above recommended approach, since the lack of adequate information regarding the relative proportion of effort devoted by part-time, voluntary teaching physicians to teaching and patient care service at this time cannot be quantified. These studies should include task analysis, cost of performing the tasks and determination of the most cost-effective apportionment for third party reimbursement. Pilot programs should be funded to serve as guides in future deliberations for improvements in this legislation.

One additional point needs to be stated. Although not specifically relevant to reimbursement, we are concerned that members of our hospital teaching faculties that have actively included their "private patients" for intern and resident education may misinterpret this part of the legislation. Cursory examination of reports of these recommended amendments to the Medicare Act could result in misinterpretation that having interns and residents participate in the management of "private patients" insured under Medicare could or would inhibit his fee-for-service billing under Part B.

To guard against this eventuality, the Association for Hospital Medical Education strongly urges that a statement be included in the legislation amendments declaring that it is common and appropriate practice that interns and residents participate actively in the management of "private patients" with their attending physicians.

Mr. Chairman, we sincerely thank you again for this opportunity to comment. We strongly urge consideration of our recommendations.

Senator Ribicoff. Our next witness is Dr. Robert Chase, the Association of American Medical Colleges.

In all fairness to you, Dr. Chase, we are going to have to recess at 11:30. I would dislike to put you on for 5 minutes unless your testimony only takes 5 minutes and then shut you off. It is the intention of the committee to recess to 3:30 p.m. at which time we will resume and hear the other witnesses who are scheduled. Both Senator Williams and I and Senator Bennett have extensive duties to perform, and in a little conversation we feel we can clear our own office and Senate calendars and be back here at 3:30 p.m.

What would you prefer, Dr. Chase? You have got 5 minutes, would you rather start now?

Dr. Chase. No, we would prefer to return at 3:30 p.m.

Senator Ribicoff. Then the committee will stand in recess until 3:30 p.m. and the other witnesses who haven't been heard will have an opportunity to testify at that time.

(Whereupon at 11:25 a.m., the hearing was recessed to reconvene at 3:30 p.m., of the same day.)

AFTERNOON SESSION

Senator Ribicoff. The committee will be in order.

Dr. Chase, please.

STATEMENT OF DR. ROBERT A. CHASE, CHAIRMAN, DEPARTMENT OF SURGERY, STANFORD UNIVERSITY SCHOOL OF MEDICINE, AND CHAIRMAN, ASSOCIATION OF AMERICAN MEDICAL COLLEGES' COMMITTEE ON MEDICARE AND MEDICAID; ACCOMPANIED BY DR. T. STEWART HAMILTON, PRESIDENT AND EXECUTIVE DIRECTOR, HARTFORD HOSPITAL, HARTFORD, CONN., AND CHAIRMAN, COUNCIL OF TEACHING HOSPITALS; DR. JOHN W. PATTERSON, DEAN, UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE; AND DR. ROBERT S. STONE, DEAN, UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE

Dr. Chase. Mr. Chairman, ladies and gentlemen, I am Dr. Robert A. Chase, chairman of the department of surgery at Stanford University School of Medicine and also chairman of the Association of American Medical Colleges' Committee on Medicare and Medicaid.

With me today are Dr. T. Stewart Hamilton, president and executive director, Hartford Hospital, Hartford, Conn. and chairman of the Teaching Hospitals; Dr. John W. Patterson, dean, University of Connecticut School of Medicine, and Dr. Robert S. Stone, dean, the University of New Mexico School of Medicine.

Senator Ribicoff. I am just curious, is it just coincidental that you have Dr. Hamilton and Dr. Patterson here today?

Dr. Stone. Just fortuitous.

Senator Ribicoff. I have the highest respect for the qualifications, and the ability of both Dr. Hamilton and Dr. Patterson, whom I know very well, but I was just curious whether the fact that the acting chairman comes from the State of Connecticut brings these two gentleman from all the United States.

You may proceed, sir.

Dr. CHASE. The association represents all of the Nation's 105 medical schools, 379 of our leading teaching hospitals, and 34 academic societies from both the basic science and clinical disciplines. Because of this broad representation, I believe we can speak effectively for the typical academic medical center which includes the medical school, the faculty and the teaching hospital.

Senator RIBICOFF. Will you for the purposes of the record tell us just what is a teaching hospital and what makes a teaching hospital different from a regular hospital?

Dr. CHASE. A teaching hospital, Senator, is any hospital where there is a program of graduate medical education, whether it is related to a medical school directly or not. It is qualified by certain accrediting bodies as a teaching hospital.

Senator RIBICOFF. You mean it is not just a question of preparing nurses, it is to prepare interns or residents or doctors?

Dr. CHASE. In the sense that we are using it today, sir, it is only the institution involved in graduate education for physicians.

Senator RIBICOFF. All right.

Dr. HAMILTON. Including approved residencies in such areas as medicine, surgery, pediatrics, obstetrics, gynecology, and psychiatry.

Senator BENNETT. May I ask a question? Are there non-teaching hospitals which take interns?

Dr. CHASE. No, we would consider such a hospital a teaching hospital.

Senator BENNETT. Okay.

Dr. CHASE. The second half of the 20th century has brought the controversies of progress to the American medical scene. The public has been made aware of the giant strides that American medical knowledge has made in relieving many aspects of human suffering and, as a result, the demand for medical services has risen sharply. This, in turn, has created some serious problems, including how to: Provide more medical professional personnel; improve the use of available personnel and facility resources; develop an improved system for the delivery of health and medical care; make high quality health and medical care available to everyone; and, provide programs and services to all at a price they can afford to pay.

The controversies which arise, relating to these problems, are: Determining the degree of Government involvement in health and medical affairs; developing leadership for the resolution of problems in the health care field; establishing closer working relationships between physicians and hospitals for dealing with health and medical care problems in the community: developing a coordinated plan to guide the implementation of innovation programs for controlling resources while providing services to patients, education of medical personnel, research in medical sciences, and management systems of health affairs; and determining the objectives of a health care system and the respective roles of practitioners and institutions in their communities.

In February of this year, the staff of the Senate Finance Committee issued a report which brought many of these controversies to the doorstep of teaching hospitals and schools of medicine. The report, in part, centered upon payment of under Public Law 89-97 for services rendered by medical staffs of teaching hospitals.

The report indicates that frequently the way in which the medical staff is organized to provide patient care does not fit the federally established requirements for payment as specified in existing legislation and its supporting regulations. I believe it imperative to emphasize at this point that the majority of medical schools and teaching hospitals in the implementation of these regulations did so in a manner which they believed to be in accord and consistent with the intent and spirit of Congress and the administration.

Parenthetically, I might add we do not defend nor do we condone abuses of the medicare program.

A documentation of the role of the teaching hospital medical staffs by the Association of American Medical Colleges is, we believe, imperative to any consideration of alteration of administrative regulations or the substance of the law itself.

Stated most simply, there are professional health and medical services rendered to patients in teaching hospitals which we consider, under any rule of equity, to be eligible for payment. Many of these services cannot be provided in other—that is nonteaching—institutions.

The fundamental question is whether or not the medical staff is organized in a manner which makes it eligible under Public Law 89–97 legitimately to receive payment for those services.

For example, one of the major problems that has been introduced relates to the conflict between the organization of the medical care structure in the teaching setting, and the legal framework that has been developed under Public Law 89–97 for the payment of physician services.

The legislation we are discussing stipulates that a single physician must be responsible for and must personally deliver the medical service. This then must be documented in conformity with regulations after which a professional fee may be paid the individual physician. On any well-organized teaching service, the professional care provided to a single patient involves more than one physician. In the teaching hospital, it is a team of physicians that cares for the patient, not a single practitioner, as envisioned by the law and regulations.

The team usually consists of an attending faculty member, residents and interns, and I would again add parenthetically that all of these individuals on the team are licensed to practice medicine, the intern being an exception since his licensure is somewhat limited to his practice within the institution.

The team usually has primary responsibility for every hospitalized patient on its service. That responsibility encompasses simultaneously the care of patients, the teaching of medical students and the mutual teaching and learning interchange between members of the team.

Each member of the team sees the patient and discusses the patient's illness. Approaches to diagnosis and treatment are agreed upon by members of the team. Certain procedures are performed by the whole team, while others are done by individual members of the team, on the team's behalf. Within the team, the senior faculty member, attending physician, is responsible for the quality and character of the care given to the patient and for the overall functioning of the team.

I would add that the obligatory peer review and model role for teaching that occurs under these circumstances assures high quality. The fact that there is with each patient an analysis and conceptualization of specific action, which are essential in patient care, have as a natural byproduct teaching.

Teaching within the team is in fact inseparable from the care of the patient. We are gravely concerned that this organizational structure of physician services rendered within the teaching setting has been less than completely understood. The result has been crippling legal restrictions which have worked in direct opposition to the intent of the authors of medicare.

We believe that there is a legal obligation for the medicare program to provide the appropriate level of payment for medical services of the teaching physician insofar as he is also the patient's attending physician. This adds substance to the objectives of the medicare legislation, which are to allow the beneficiary free choice of physician care and its mode of delivery, and improvement of the quality of care for the elderly.

In reimbursing physicians' services in a teaching setting, the basic problem has been to develop appropriate criteria to distinguish between a physician's teaching and administrative services which can be covered only under the hospital insurance program on a cost basis (part A) and a physician's personal services to patients which can be reimbursed only under the medical insurance program on a fee-for-service basis (part B.)

We submit that criteria for distinguishing between teaching and patient care needs to be responsive to the wide variety of teaching settings in which physicians practice and teach. At the same time, we suggest that the best criteria will not meet this need unless these criteria are properly and consistently applied by carriers, with consideration for the administrative difficulties which arise from the large variety of teaching and care delivery systems.

The nature of medicare reimbursement to supervisory physicians in teaching hospitals is often related to the circumstances of the individual setting. In some teaching hospitals, as you mentioned this morning, Senator, particularly in large urban centers, traditional patient service has been provided largely to individuals of low economic status. In these hospitals much of the day-to-day and hour-to-hour service traditionally has been rendered by the resident staff, with senior staff primarily acting as supervisors.

However, one of the objectives of Public Law 89–97 was to improve the quality of physician services in these institutions. Time after time the achievement of these objectives has been documented and Public Law 89–97 has given the poor and elderly medical care of a quailty never before available to them.

A typical example of this is portrayed here from a letter addressed to the Association of American Medical Colleges from the director of the Harvard medical unit working full time at Boston City Hospital:

> Prior to the availability of support from Medicare there has been no source of support for the care of patients of the vast, poor "inner city" population served by this municipal hospital. The only moneys available to us were partial administrative salaries (usually small) for the directors of services and income derived from research or training grants, and earnings from endowed

funds of the Medical School. This has been an important basis of support for a limited number of personnel, but has not allowed expansion of patient care by staff physicians.

With the advent of the Medicare law, and the formation of a partnership on the Harvard Medical Unit, it has been possible for us to provide considerably more extensive and identifiable services to our patients. Accordingly, when I became Director in 1968, the existence of the Medicare law allowed me to request physicians, whether full-time on the staff of this hospital or part-time and practicing in private affiliated hospitals, to attend each day of the week.

Furthermore, there has been a much tighter regulation of records in which notes by staff physicians have been entered. Our patient population is one that mainly is lacking in private physicians. Those few physicians who are practicing in the central part of Boston are largely elderly men, many of whom had graduated from medical schools which no longer exist. Accordingly, the Boston City Hospital functions as the physician to the poor. If the professional system that has been built up in the last year or two is to be destroyed through lack of support, there is no reasonable substitute for the health care of these people. Alternative methods of delivering adequate health care would be considerably more expensive than those which have been implemented here.

The Association of American Medical Colleges has developed a statement of principles relating to what it believes to be the major items under consideration by this subcommittee. This statement is attached as an appendix to this presentation and, as you have suggested, Mr. Chairman, I will not read it but will ask that it be considered an integral part of this testimony.

Senator RIBICOFF. Without objection, but do not hesitate to give us the substance of your proposal because I think that is important.

(The document follows. Hearing continues on p. 604.)

STATEMENT OF PRINCIPLES

PREAMBLE

The Association of American Medical Colleges' (AAMC) Statement of principles is structured upon Section 1892 of P.L. 89-97, wherein it is stated:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

AAMC believes this guarantee of freedom of choice and acceptance should be extended to all patients in the nation.

Teaching hospitals have a special role and responsibility in the delivery of health care and the education and training of health professionals. The nation looks to them for excellence in the provision of care. Teaching hospitals are expected to provide highly skilled personnel and a broad spectrum of programs and services, education, and research. They provide the setting for the major part of the education and training of the nation's physicians and other health professionals. These obligations place an unusually heavy financial burden upon the teaching hospital.

The patient turns to the teaching hospital for a high level of health and medical services, which are unusually complex, scientifically advanced, and costly in nature, to meet his special needs. In meeting these needs, the hospital and the physician are ultimately legally and morally responsible for the quality of care which the patient receives; and to provide for this care, the hospital must maintain a qualified medical staff. In the teaching hospital, this medical staff may be organized in a variety of ways to encompass its responsibilities for services to patients, education, and research.

The availability of patients through the practice of medicine by the medical staff is essential to the education of health personnel and is important to the development of health manpower. In addition, the practice of the teaching staff is important to the community because teaching physicians are in the forefront of the knowledge of medical sciences.

STATEMENT OF PRINCIPLES [1]

These principles are written to clarify the organizational relationships in the teaching hospital. They define certain necessary financial relationships of the hospital, its medical staff and associated staff, to assist and support them in their educational as well as patient care activities.

1. *In any legislation dealing with health care, it is essential that research and development, innovation, and demonstration of new methods for the delivery of health care services be promoted. At the same time, it is important to experiment with and evaluate new methods of payment for such services.*

In developing alternative methods of organizing the teaching hospital medical staff along different delivery patterns, payment for hospital and professional services should be commensurate with the effort incurred in the rendering of that service. For example, ways could be designed to render "units of service" and payment made for these "units of service" based on reasonable charges. The hospital and its medical staff should be supported in developing ways to extend the quantity, quality, and equality of health care to all socio-economic levels of society.

2. *Every patient admitted to the hospital has the right to the personal services of a responsible physician on the hospital medical staff, in charge of his diagnosis and therapy.*

The Association of American Medical Colleges concurs that this is necessary to insure the highest quality of care possible for the patient. It is also necessary for establishing responsibility for the management of the care and for payment of professional fees. This patient-physician relationship should also exist because of medical-legal problems which extend from out-patient, emergency, and continuing hospital medical care. Further, it is necessary for the conduct of medical education, which increasingly will involve the private patient-medical staff relationship.

3. *The teaching hospital's medical staff should be organized as a team to provide continuous, direct, and personal care to patients and should develop organizational methods which guarantee appropriate access for patients, as well as availability of on-call and emergency services.*

Every patient has the freedom to choose the arrangements under which he will receive medical care. Included is the right to all of the advantages which accompany a close relationship between the responsible physician and his associated staff in education as well as practice.

4. *A charge should be made for all hospital and professional services rendered to patients.*

Improvements in the payment for medical services, while still not adequate, have affected the relationships among patient, doctor, hospital, and the payor. Since there are increasingly fewer individuals without some form of health insurance, this change in relationships requires development of a greater understanding between hospital and medical staff organizations relative to hospital costs and professional charges. The payors must also recognize the implications of inadequate reimbursement for patient care in the teaching setting.

5. *Any member of the hospital medical staff rendering professional services to the patient is eligible for payment for such services. The medical staff and associate staff should be organized for rendering services to patients in a manner which will allow accountability for charges submitted. The senior resident and/or chief resident may be considered eligible for appointment to the medical staff with appropriate limitations on his privleges.*

Since the medical staff of the teaching hospital is departmentalized and the associated staff is assigned along these departmental lines, all physicians restrict their practices to a greater or lesser degree. It follows that the senior resident and/or chief resident can accept responsibility for the medical care of patients within limits set by the senior medical staff members who are responsible for the conduct of his education, training, and experience. Senior and chief residents may be assigned responsibilities similar to those of the attending physician personally assisting interns and other residents with the care of patients. They may render consultations.

6. *As an acceptance of public accountability, the teaching hospitals and medical staff agree that a professional audit of patient records and other pertinent documents should be continued and that documentation describing professional services rendered be incorporated into the patient's medical record.*

[1] It is to be emphasized that these principles relate to the teaching hospital and its medical staff and not to the medical school itself, except as the medical school faculty participates in the delivery of medical care.

7. The teaching hospital must have adequate financial resources for current operations, new and/or expanded programs as well as capital uses.

The teaching hospital's expansion of scientific competence is in direct response to the growth of the body of medical knowledge. This growth imposes new requirements for space, equipment, and personnel to bring to patients the best in modern medical care.

The special nature of the teaching hospitals in their capacity of providing high quality, frequently innovative medical care, in providing an environment for teaching and scientific research, and in setting standards of excellence, have caused the costs of providing care in these hospitals to rise. As the hospitals attempt to meet the increase in public demand for services, and as they meet expanding modern scientific standards, requiring more highly skilled personnel, this trend is expected to continue. At the same time, however, teaching hospitals have a special obligation to improve the management of patient care, to maximize the use of available resources, and to minimize the patient's length of stay.

The teaching hospital is the environment in which medical scientific knowledge and skills are translated into innovations in methods and equipment for the delivery of high quality medical care. Growing specialization in medicine requires greater coordination of patient care management to avoid undue fractionation. However, new or expanded programs or services should be related to the demonstration of need.

DEFINITION OF TERMS

1. Personally Rendered Professional Services

In the teaching hospital, the quality of care rendered to all patients should not be determined by economic status or the method of entry into the health care system. Each has a responsible physician who personally rendered care.

The responsible physician may utilize the professional services of the associated staff or other staff members, creating a team-of-physicians approach to patient care. To qualify for billing and collecting the professional fees for such services, there should be evidence that the responsible physician has personally rendered the care having reviewed and coordinated all care rendered by the team. Further, during technical procedures, such as surgical operations, the responsible physician must be present even though he may not be the operating surgeon of record. This means that the patient is informed of the team members. It is understood that, as a member of the team, the responsible physician may only observe the procedure, being immediately available to perform the surgery if needed.

"Personally rendered professional services" also includes those services provided by a member of the hospital medical staff, at the request of the patient's responsible physician, and with the patient's knowledge. It is necessary that an opportunity be provided to make a unit charge for the total service rendered in the diagnosis, treatment and follow-up of an episode of disease. In the teaching hospital, the unit of service involves the medical care team and the reimbursement should be negotiated to cover appropriate charges for the care rendered.

2. Medical Staff Patient

A patient who has chosen a member of the hospital's medical staff, or has accepted a practicing physician assigned by the medical staff of the hospital to personally provide and be responsible for his medical care. Assignment of a physician is accomplished in accordance with established policies and procedures agreed upon by the medical staff and the hospital.

3. Attending Physician

A physician who has been appointed by the hospital to the hospital's medical staff, to personally provide and be responsible for the care of the patients.

4. Responsible Physician

A physician who has been appointed to the hospital's medical staff who assumes the responsibility for providing or observing personally the medical care of his patients. The responsible physician may be a faculty member, a chief resident, senior resident or any other member of the medical staff.

5. Eligible

Professional fees may be billed for services rendered by the medical staff. Professional fees may be billed for services rendered by the associated staff when a responsible physician is personally present.

6. Associated Staff

The interns, assistant residents, residents, senior residents and chief resident physicians who are appointed to the hospital's approved teaching programs by the medical school faculty, the hospital's medical staff and the hospital.

7. Assistant Resident

A physician who has been appointed to the hospital's graduate education staff but has not yet attained the final year or two years of specialty qualifications (as described in #8 below).

8. Resident

A physician who has been appointed to the hospital's graduate education staff and has attained:

(*a*) Final year of a two- or three-year program, or
(*b*) The final two years of a four-year or longer program.

9. Senior Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He may be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. He has the training chronology of the chief resident on the specialty service, but does not have that designation.

10. Chief Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He can be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. The designation of chief resident and the selection of the chief resident is a function of the medical school faculty, the hospital's medical staff, and the hospital.

11. Medical Care Team

As referred to in these principles and accompanying documents, the team consists of a responsible physician from the hospital's medical staff working with one or more members of the associated staff. The team in special care situations may also include other members of the hospital's medical staff working with the responsible physician and members of the associated staff.

Dr. Chase. I will be pleased to answer any questions about this statement of principles, and I am sure in our continuing conversation these principles will come out.

A basic consideration underlying this position of the Association of American Medical Colleges is that unless the medicare patient is provided the means of paying his own way, he would not continue to receive the high quality physicians' services now available to him in the teaching setting, specifically that just mentioned in the quotation.

I have stressed the very positive and beneficial effects which Public Law 89–97 has had in providing an access for all of the aged and poor to a single standard of care and we fervently believe that this access must be preserved and strengthened. One area that shows particular promise for strengthening this access point lies in experimentation and innovation with new methods of delivery of medical care, specifically with regard to the provision and reimbursement of surgical or medical services in a teaching setting.

Any system of remuneration which puts a premium on withholding patients from the teaching setting threatens the supply of well-trained specialists and deprives patients of some of the best medical care available.

We recognize that officials of the medicare program have, at the moment, only limited statutory authority to depart from traditional cost reimbursement and fee-for-service concepts on which the program is based.

Amendments to the legislation in 1967 authorized some experimentation with various alternative methods of reimbursement to pay institutions and physicians under the medicare and medicare programs. This experimentation provision grew out of the concern that a rigid commitment to traditional reimbursement patterns would not provide sufficient incentive to furnish high quality health care economically and effectively.

In support of broader authority for medical care delivery innovation which we urge you to consider, a statement by Mr. Arthur E. Hess, Deputy Commissioner of Social Security, is appropriate to add at this time, and I quote:

> Teaching hospitals offer some of the most intriguing possibilities in coverage and reimbursement. The fee-for-service arrangements that have developed over the years in the context of solo practice are not necessarily the most appropriate in a teaching setting in which the team approach is used. Under the proposals models could be developed at limited numbers of teaching institutions that better accommodate to the unique mission and modus operandi of the teaching hospital. Those models that prove to be more compatible with the policies and practices of the institution and also prove successful in strengthening utilization and cost effectiveness could then be applied generally.

In closing my statement, Mr. Chairman, we believe that our medical schools and teaching hospitals are prepared to meet the challenge of finding better methods to provide medical care of highest quality to patients, while at the same time try to meet the needs of medical education and fulfill the responsibilities of the medicare program.

Thank you very much.

Senator RIBICOFF. Senator Bennett.

Senator BENNETT. Thank you, Mr. Chairman.

Are you gentlemen aware that both the Social Security Administration and the General Accounting Office have auditing teams now in about a dozen teaching hospitals following up general information they had which would indicate that there might have been overcharges in those hospitals, as there were in Cook County Hospital in Chicago?

Dr. CHASE. Yes, sir; we are aware of that.

Senator BENNETT. I do not think it would be proper under the circumstances to mention the names of the hospitals.

Is your association concerning itself with those, are you following them as they develop? Have you been making sure that you understand what the problems of those hospitals are and how they apply to your hospitals?

Dr. CHASE. That is the basis, essentially, Senator, of much of the activity of our committees during the last year.

Senator BENNETT. You did not read your recommendations. Do your recommendations contain specific suggestions based on your observation or your reaction to these audits?

Dr. CHASE. Yes. I think many of the recommendations are addressed specifically to the problems that have arisen, misunderstandings of the means of payment under medicare for specific institutions; yes, sir.

Senator BENNETT. The dean of your medical school, Dr. Robert Glaser, in a letter to the Director of the Bureau of Health Insurance, has suggested, and I quote:

> That medicare reimbursement be entirely on a cost basis, with that portion of faculty services allocable to direct patient care included in the hospital cost claim.

Do you agree with the dean that this is a good approach to the problem?

Dr. CHASE. I think this is an available alternative, but as you look at the whole letter you will understand it has emerged as a result of suspension of payment to our institution for services rendered, and the likelihood that this will continue unless we come up with some alternative system.

I do believe that this is one very excellent way to set up an experimental program that could very well prove that delivery of medical care in a teaching setting might very well be done with the production of high quality medical care at less cost than the alternative in the nonteaching sector.

I think we might discuss for a moment what cost basis means, however, because cost basis might mean different things to different people. If we were to compute a cost basis in our own institution, as has been suggested by the dean, and in his letter he points out that we could compute this on a cost basis, we would include in our cost claims, in addition to the elements now contained, the portion of faculty salaries apportioned to direct patient care. We would then have to agree on methods for determining the portions of our total costs which will be properly chargeable to Government programs.

When we say on a cost basis it would mean cost, that contains all presently accountable faculty salary costs, and undoubtedly a research and development cost.

Senator BENNETT. Well, I think the Government would assume that you would just include the faculty salary involved in patient care in the hospital rather than all of these other costs which are already paid under part A, are they not? The hospital already has these administrative and other costs available under part A.

Dr. CHASE. Senator, the present source of some of the research and development costs, as has been pointed out by your own staff, comes, in fact, from earnings of faculty members in the institution. His take-home pay is being taken into consideration.

Senator WILLIAMS. Would the Senator yield?

Do you think all of these costs should be included as a part of reimbursable expenses?

Dr. CHASE. Would you repeat that?

Senator WILLIAMS. Are you suggesting that all of the costs of teaching be included as a part of reimbursable expenses?

Dr. CHASE. No. But there is considerable contribution on a voluntary basis from the earnings of faculty members toward teaching in the institution.

There is a differential between the salary level which individual faculty members receive and the potential earnings of these same faculty members were they to pocket the earnings rather than contribute it to the institution.

The faculty members, in fact, voluntarily allow these funds to be used to support the medical education program. It does not fully support the program by any means.

Senator WILLIAMS. The ones you are teaching, are these interns who are trying to complete their education?

Dr. CHASE. These men are interns who are in the first post-MD year. This first post-MD year will qualify them for licensure in any of our

States, following which they have a choice. They may go into private practice, in which case they are eligible to receive the full 100 percent payment under part B of medicare. If they remain within the institution under the essential jurisdiction of the faculty and teaching group as members of a team, they are reimbursed under part A for only that portion of their salaries that can be attributed to the care of medicare patients.

Senator RIBICOFF. I wonder if the Senator would yield? I am just curious whether you or the staff have ever put aside in two separate columns the comparative costs. In one case John Jones goes into a hospital when he has a private physician taking care of him without a teaching hospital.

That same John Jones goes into a teaching hospital receiving the services that he is receiving, and what bill will then be sent to the fund? Do you have——

Dr. CHASE. Yes; we do have that information.

Senator RIBICOFF. How does that come out?

Dr. CHASE. We have in our own institution computed the comparative costs for the care of a patient in our particular teaching setting as opposed to the total costs for the care of the same disease state in a similar patient in the nonteaching sector, and it is less costly in the teaching setting.

Senator RIBICOFF. Isn't that, then, basically the problem that we face here, as I see it, that if your method does not add any additional financial burden to the social security fund, there is certainly no reason to deny the teaching hospital or the teaching medical school that same reimbursement and the services a patient is receiving are probably a lot better than he is receiving from an individual physician.

Dr. CHASE. That we feel, Senator, is precisely correct.

Senator RIBICOFF. I wonder if the staff could enlighten us whether the staff came to the same conclusion as Dr. Chase has come to.

The question that I was asking of Dr. Chase, was whether they have ever computed the cost to the social security fund of John Jones, a patient who is under the care of a private physician in a community hospital, as compared to the same cost for the same injury, the same disease, in a teaching hospital or university.

Dr. Chase made the response that he thought that the costs were probably slightly less in the teaching hospital, the medical school, than they would be for the private doctor working in a community hospital. Have you ever computed that comparison?

(Whereupon, there was a short discussion off the record.)

Dr. CHASE. I could hear what the staff said, and they are correct. The overall costs are generally higher in a teaching hospital, but that is based on the fact that the teaching hospital is the court of last resort. It receives the most complex, most complicated problems to deal with. These happen to be the most expensive patients to care for.

For example, the open heart surgery patients, the very complex disorders, patients who require organ transplantation, and so forth. The expense for such care is unduly high, and thus the overall cost may be higher in some cases.

Senator RIBICOFF. That is not the point I make. It is not the overall costs.

But take a patient, John Jones, who is a patient with the same injury or the same disease who is being treated by a physician——

Dr. CHASE. Correct.

Senator RIBICOFF (continuing). In a community hospital or a private hospital, and the same patient with the same disease being treated in your hospital.

Dr. CHASE. Correct.

Senator RIBICOFF. I can understand that the overall costs would be higher because you get the complicated cases.

Dr. CHASE. Right.

Senator RIBICOFF. But the same disease and the same treatment.

Dr. CHASE. I would stand on my statement that it would be less costly in the teaching setting. For example, in my own area of competence, which happens to be surgery, there is an elimination immediately in the professional costs of 20 percent because there is no assistant's fee involved in the teaching setting. That is a simple example of one of the compensating elements.

Generally, the billing on the part of faculty members in the teaching setting is somewhat lower as far as professional billing is concerned for treatment of the same disease. This is another example.

Now, it is true that teaching hospitals generally are expensive hospitals and, therefore, it is conceivable, based on the total cost for a single disease, that the day rate, and so forth, might be somewhat higher in the teaching hospital just by virtue of the complex nature of that institution.

But let us make a proper comparison and say in the same institution where side by side there are patients being treated, for example, with acute appendicitis, one by the teaching service or the university service, and the other in the nonteaching sector, I can assure you that the cost would not be more, and would likely be less in the teaching setting where the team is involved.

In addition, there are other advantages that occur in the teaching setting, particularly with regard to the complex medical and surgical problems. With the team services there is constant available consultation. Generally, these consultations are not specifically and separately billed for.

Senator WILLIAMS. How do your bills compare with those prior to medicare?

Dr. CHASE. In our own institution since 1959, we had never taken an indigent patient. Since that time, until medicare came, our hospital was not available to the elderly poor. Since the advent of medicare, the elderly poor have had our institution available to them, but the fact is that we are presently in terrible financial trouble.

Senator WILLIAMS. The elderly under medicare are not necessarily all poor or poverty stricken.

Dr. CHASE. No; that is correct.

Senator WILLIAMS. So I am asking, how did it compare for those who paid before medicare and those who are now paying under medicare?

Dr. CHASE. Precisely the same before and after medicare in our institution.

Senator WILLIAMS. How about other institutions?

Dr. CHASE. In other institutions it varies, as Senator Ribicoff mentioned this morning, from involvement of the teaching physician all the way from relatively minor involvement in the care of the patient, to total care of the patient in a sense by the attending physician or surgeon.

Senator WILLIAMS. Did they charge for supervisory physicians' services before medicare the same as they do now?

Dr. CHASE. In our institution; yes, sir.

Senator WILLIAMS. In general.

Dr. CHASE. I cannot answer that for every institution, but I think it has varied a good deal institution by institution. For example, at the University of Chicago, there always has been such a charge.

Senator WILLIAMS. Yes.

You heard Dr. Hall's testimony this morning; did you not?

Dr. CHASE. Yes; I did.

Senator WILLIAMS. He did not quite agree with you, as I understood it.

Dr. CHASE. I would not find a great disagreement with the statement presented this morning. I think the system described was quite correct. That is one of the methods by which medical care delivery can be carried out in a teaching setting. It is only one, and I am now saying there is a great variety of possible means of delivering medical care. The one constant common denominator in the teaching setting is high quality.

Senator BENNETT. In a speech to your organization last year, Dr. Ebert, dean of the Harvard Medical School, said:

If house staff have primary patient responsibility and are paid from Part A of Medicare, can the service collect again by charging the professional fee in the name of the visiting physician? The dilemma is obvious. It has been the tradition of some of the best teaching services to advertise that substantial responsibility for patient care is delegated to interns and residents.

I guess, in order to attract interns and residents.

Now, the same teaching service must insist that it is really the visiting physician who has the responsibility and not the house officer.

It is difficult to make these two arguments sound convincing when they are made simultaneously by the same person.

Dr. CHASE. What Dr. Ebert says is, it is difficult but not impossible because it happens to be true. He then explains that situation in the paragraphs that follow, and I would like to make those a matter of record.

Senator BENNETT. By all means.

Dr. CHASE [reading:]

The misfortune is that the present form of third party payment, in either public or private sector, does not take into account what really happens in a teaching hospital. The form of payment assumes that there is one doctor who is responsible and should be paid, and that no others are involved.

This, of course, is patently absurd. On the usual teaching service there are multiple physicians and even when the intern or resident is given primary responsibility, he is assisted in many ways. It simply isn't true that one doctor alone carries the entire burden.

I will skip some of this, if I may, but request that the entire article be made a matter of record, and go to some of the points that are made.

The fact is that on the usual teaching service a team of physicians cares for the patients. It seems to be an error in public policy to assume a method of payment for professional care which ignores the nature of the service paid for.

This is from the same distinguished Harvard Medical School dean, and there is more, which has a tendency to support his notion that it is difficult to make these two arguments sound convincing. I must say it does sound convincing to me as I complete the reading of this paper.

Senator BENNETT. Well, we are having fun reading Dr. Ebert back and forth to each other.

On page 111, at the bottom of the first column, he said:

"There is one final problem which is worth noting. The fees collected on teaching services are meant to represent payment for patient care. Yet it is evident that they will be used in part to support teaching."

This is precisely what we did with funds designated for research, and this time I submit that we would do far better if we indicated that this is not the best way to support medical education, and that is one part of the dilemma.

Dr. CHASE. Correct. And I wholeheartedly agree with Dr. Ebert where he says that under the present circumstances, it is the only alternative available to us for the support of private medical schools.

In fact, it is not a support of the private medical school or the educational program by the Federal program. It is support of these institutions by the faculty of that school since, in fact, if they were to take the fees so generated under part B and keep them, they would be eligible to receive those fees. In other words, the decision as to whether or not they are to be paid will depend on what the teaching physician decides to do with those fees. If he decides to use them for his own personal use he is eligible to receive such payment. If he turns those fees over to his medical school by some previously agreed upon system, he is no longer eligible to receive those fees.

This seems to me to be incompatible.

Senator WILLIAMS. Did I understand you to say that prior to medicare doctors turned their fees over to this system?

Dr. CHASE. In my own institution, yes, sir, they did; as they did in every full-time university medical school.

Senator RIBICOFF. I think we do have a great dilemma. It would be, I think, tragic, to prevent the continuation of teaching hospitals and medicals schools.

Having gone through an experience with a member of my family in a medical hospital, for the first time I have seen the utilization of a team, so I know what you are talking about.

The chief surgeon has a team of about five or six people. Every time they came to see the patient, the chief surgeon had the entire group with him.

Now, when he was in the operating room in another operation, the patient had to have care in intensive care, and supplementary care, and there was always somebody on his staff and on that floor ready to render that service, take the history and take care of the patient during various times of the day and night.

Now, I have not the slightest idea yet how that is going to be billed and what the problem is. Of course, it is a nonmedicare patient, but it is very obvious to me that no one doctor in this type of an operation could possibly handle it. It would have to be done by a team. No one doctor could do it.

Dr. CHASE. Senator, I agree precisely with what you said. As a matter of fact, you have made a very good case, I believe, for the justification for payment of house staff under part A of the program. As a

hospital resource, as you have just mentioned, the interns and residents provide a service of great value to patients above and beyond traditional professional care in the nonhouse staff hospital.

As you mentioned, if the surgeon was in the operating room, there is at least one member of the team always readily available. The resident staff provides more continuity of medical service than any mechanism thus far discovered. It amplifies and supports the work of the attending physician, which you also have just mentioned, who is responsible for the patient's care rendered by the team.

In terms of the long hours which recent surveys indicate these physicians devote to patient care, the cost is extraordinarily low. This cost should be recognized and provided for as one of the most important elements of hospital service under part A. Until such time in his career as a physician is qualified to collect reimbursement under part B, the patient is entitled to supervision of his work by a fully qualified member or members of the professional staff. Such responsibility and supervision should be reimbursed under part B, under regulations as published in the Federal Register.

Senator RIBICOFF. Have you sat down with the staff of this committee, and someone from the Social Security Administration, to try to work this dilemma out so that the fund would not be paying a larger total cost for the same service being received because the person is in a teaching hospital and has a staff taking care of him instead of an individual physician?

Dr. CHASE. Senator, we have made that case to the House Ways and Means Committee. We have made that case to the Social Security Administration, and we find them in general agreement with us.

Their dilemma is the same as ours, and that is that we cannot fit the legislation to anything but the traditional one doctor-one patient relationship. Although they recognize that high quality care is being delivered and that it is being delivered at less cost as compared with what could be done in the nonteaching sector, they throw up their hands, saying, "But there is nothing we can do because of the nature of the legislation."

Senator RIBICOFF. Well, I mean, that is not so. I mean, you can always change the legislation.

Dr. CHASE. Correct, and that is our intention to try and spearhead such change.

Senator RIBICOFF. Basically, in the normal development of clinics, whether it is the Mayo Clinic or the Leahy Clinic, or the great medical schools with their great medical hospitals associated with them that are rendering service all the time, it is not an individual doctor, and there is no question that thousands upon thousands of people are being served, and also medicine is being advanced because no individual doctor, no matter how brilliant, could possible take care of many of these complicated illnesses.

Dr. CHASE. But, Senator, you have a unique perception of this whole problem. It is not easy to make this explanation to those people who can only understand the traditional 1-to-1 physician relationship.

I agree with you that legislation should be changed to adjust to this situation, particularly when the highest quality care can be delivered

at less cost to the beneficiary and, therefore, to the Federal Government.

Senator RIBICOFF. In other words, you are boxed in because of the legislative language.

Dr. CHASE. We are, sir, and the other thing is that an incorrect comparison has been made. The comparison that has been made is the comparison of costs in a teaching institution such as ours with no cost at all.

This never did exist in our institution. In other words, it has not been a cost comparison between what happens in the teaching institution and the nonteaching institution. It has been a comparison between the costs under medicare, should it be reimbursed by these various and sundry methods, versus no costs at all, which, obviously, is impossible, particularly in a private institution.

Senator RIBICOFF. When you talk about private institutions, after all, you may have a State medical school——

Dr. CHASE. Correct.

Senator RIBICOFF (continuing). That has the same problem, and that is a public institution or a city institution.

Dr. CHASE. Quite right.

Senator RIBICOFF. So when you are talking private, it would basically be the same problem with every medical school whether it was a private school like Yale or the University of Connecticut or Stanford and the University of California.

Dr. CHASE. That is quite correct, except there are conceivable potential alternate sources in the State institution where there are none in the private institution. But you are quite correct, this is true for all institutions, both the State institutions and the private institutions.

Senator RIBICOFF. I wonder if you gentlemen would please stay until we conclude the hearing. The staff might have some questions, and I know the hour is late, but it would save you an extra trip here, and if you could oblige us by remaining until we are through.

Dr. CHASE. We would feel that we were being obliged, sir.

Senator RIBICOFF. Thank you very much.

The next witness is Rev. William T. Eggers.

STATEMENT OF FRANK G. ZELENKA, ASSOCIATE DIRECTOR, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. ZELENKA. Senator Ribicoff, my name is Frank Zelenka. I am the associate director of the American Association of Homes for the Aging. Reverend Eggers had to leave to go to a board meeting in Chicago and, with your permission, I will fill in for him.

I will not go through the statement which has been filed with the committee in its entirety, but I would ask that it be included in the record of the proceedings.

Senator RIBICOFF. Without objection, your entire statement will go into the record as if read.

Mr. ZELENKA. I will simply address myself to two or three points that we have among the seven or eight that are in the formal statement.

You heard discussion here in terms of efforts to reduce the costs of the program. Perhaps, what I am going to address myself to now will add to the costs of the program, but we are very troubled by a phenomenon that has taken place since the advent of this program. Since

the advent of this program, the proprietary sector has probably doubled in the number of for-profit facilities. This proliferation of for-profit facilities has not been accompanied by a similar growth in ongrowth facilities. As a matter of fact, the nonprofit sector is pretty much—has pretty much stayed in place.

We have made an effort to look for an analog to the return on equity capital which is now provided to the proprietary provider. If you will examine the language of the principles of reimbursement, the rationale for granting that return on equity capital is that such capital needs to be attracted to the field so as to draw in the discouraged.

We submit a similar analogy exists in the nonprofit sector as regards philanthropic problems. If we couch this language in terms of the language of the entrepreneur, many nonprofit eleemosynary corporations stand in that same category. They receive gifts that are unrestricted and have a decision to make as to which of many eleemosynary activities they will apply those resources to.

It would seem the same encouragement should exist to attract into and to apply those resources for providing extended care as does exist now for the proprietary provider. I have in mind, for example, let us say, an institute such as the Jewish Federation of Philanthropies, the Catholic Charities, what-have-you. These are nonprofit corporations. They receive gifts. There are many eleemosynary activities to which they could apply those resources, camps for disadvantaged children, parochial schools, there is a whole galaxy to which those funds could be directed.

If private capital, seeking a profit, is to be encouraged for entering into this field of providing extended care, it would seem a similar enducement ought to be provided to that type of organization to apply its resources to this field.

We feel that if such an increment is not found, the Nation is faced with something that may have vast social implications in this entire field of providing extended care so that it may become a complete for-profit venture.

We do not have the answer to this problem. We are studying it, and in our statement we simply ask the committee and the staff to give thought to this problem.

We make another recommendation in our statement which is addressed to the intermediate care program. We think there exists an acute need to define this whole area of services. The statutory definition is something more than room and board at the same time something less than skilled nursing care.

We think this program—we agree with the staff of the committee that thus far it has been negatively approached, and I believe it is something that five or six States exist that have considered this program.

It has been negatively used as a refuge for substandard facilities, as the committee staff indicates. It has been used by some States as a device to cut their costs by reclassifying patients who require skilled care and placing them in so-called intermediate care.

We think a great opportunity exists to make this program the answer and companion of title 18 and title 19 by having our medical programs provide those services for the aged which are not encompassed by titles 18 and 19.

We think very serious consideration should be given to making the reimbursement under intermediate care, as in the medical one, based on reasonable cost. This could be the positive answer to much of the service that the needy aged require.

My last remark will be to suggest to this committee that it consider an amendment to section 1908 of the Social Security Act, that is, the so-called Kennedy amendment which originated in this committee in 1967 and which would require the licensing of nursing home administrators.

We think that this program has tremendous implication for the future. It is probably one of the most positive instruments to operate in the entire field. This committee wanted to put forth this amendment in 1967, and wisely provided that the board of examiners that will do the licensing in a given State be a representative group, representative of the profession, of the institutions engaged in care of the chronically ill and infirm aged.

We believe the time has shown deficiencies in that wise provision in that it did not prohibit the existence of a majority from a single type of profession or a single type of institution.

We think the great thrust of this licensing will not be to today's administrator but to tomorrow's administrator.

If that is to be achieved, that impact is to be felt in two or three years, the emergence of long-term health care administration as a profession requires wide judgment of the many disciplines that are involved in providing that care, and we think that an amendment that would preclude such a majority would enhance the emergence, quicken the emergence, of top quality administrators.

Thank you, sir.

(The prepared statement follows:)

SUMMARY—TESTIMONY: AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Principal Witness: Rev. William T. Eggers, President.

Accompanied by: Edward Munns, President-Elect; Lester Davis, Executive Director; Frank G. Zelenka, Associate Director.

PRELIMARY STATEMENT

1. Medicare and Medicaid have been outstanding successes. Both programs have provided the aged with access to vital medical care.

2. The nation is indebted to the Congress, the House Ways and Means Committee and the Committee on Finance of the U.S. Senate for Medicare and Medicaid.

3. The Staff of the Senate Committee on Finance is to be commended for its outstanding Report on Medicare and Medicaid, issue on 9 February 1970.

I. THE FISCAL IMPACT OF MEDICARE: PRIOR HOSPITALIZATION

Recommendation.—We would urge the Committee to consider a provision whereby, in the event a beneficiary suffers a reoccurrence of that condition for which he had previously received extended-care benefits, or there should develop a condition directly related to that condition for which he had previously received extended-care benefits, and for which, in either case, it is medically determined that in-patient extended-care services are required, but not in-patient hospital services, then not withstanding the fact that the beneficiary had been discharged from an ECF for more than fourteen (14) days, said beneficiary could be admitted directly to the ECF without a prior hospitalization but with a medical determination made by the hospital through its out-patient service.

Opinion.—It is our thought that such a provision would be in keeping with the intent of Congress that a medical alternative to hospitalization be utilized whenever the occasion permitted it. Such a provision should result in a more efficient

utilization of the program with an attendant reduction in its cost. It is expected that in every instance the definitions of extended care and skilled nursing care would be adhered to along with an equally tight definition of the term "medically determined."

II. REIMBURSEMENT OF INSTITUTIONS PROVIDING MEDICAL CARE

We concur in the Staff's recommendation that capital expenditures should be tied into planning. However, we would ask that the Staff consider that planning ought to take into consideration those constituencies which are not limited to the immediate geographic area. Ethnic and religious constituencies are frequently state-wide and even region-wide. When this is true, the facility serving such a constituency ought not to be prevented from expanding because its immediate geographic area is deemed to require no additional beds.

Prospective Reimbursement

Like so many others, AAHA is studying the concept of a prospective reimbursement. It is our thought, however, that such reimbursement should be related not only to prevailing charges but also to prevailing costs within a given area.

Demonstration Project

It is our hope that this Committee would recommend authority for the Secretary to engage in reimbursement demonstration projects involving not only hospitals but also some involving long-term care facilities, which projects would demonstrate the priciples set forth in the AHA publication: Financial Requirements of Health Care Institutions and Services.

Return on Equity Capital

The Association also takes this occasion to recommend to you that thought be given to allowing to non-profit providers of long-term care an increment of reimbursement analogous to the return on equity capital presently permitted to for-profit facilities.

It is our thought that there exists an analogy between the "philanthropic capital" furnished by non-profit facilities and the "proprietary capital" invested in for-profit facilities. These two differ from each other only in that the return earned by each is in the case of proprietary capital utilized for personal gain, whereas that earned by philanthropic capital is utilized for the same eleemosynary purpose or for another such purpose by which, in either case, the public-good is intended to be served.

The rationale for the return on equity capital for proprietary providers is that of encouraging the investment of such capital in the field of providing extended care and that of discouraging the withdrawal of such capital. We submit that the same rationale exists for a return on philanthropic capital invested in non-profit facilities for a specific eleemosynary activity. Like any entrepreneur, the eleemosynary organization has a choice of activities in which it could apply, that is, invest its resources. Like any entrepreneur, it should be allowed to earn a return on its equity capital which is given over to the activity resulting from its entrepreneurial decision to provide extended care to the aged. Like the proprietary provider, the eleemosynary organization should be encouraged to apply its resources to this field and not to some other eleemosynary activity.

It is evident that the inclusion of a return on equity capital for proprietary facilities has succeeded in encouraging the investment of capital in such facilities: witness, the phenomenon of the so-called "chain operators." The proliferation of for-profit institutions has not been paralleled by a similar increase in non-profit facilities. On the contrary, our experience is that the number of non-profit voluntary homes has been diminished or frozen into place.

It is our considered opinion that in an increment similar to the return on equity capital enjoyed by for-profit ECFs is not soon made available to the non-profit ECFs, we may likely kitness the occurrence of a social phenomenon, with vast implications, wherein necessary extended-care services to the aging in America will wholly or almost wholly a for-profit venture. We urge the Committee to study this matter.

AUDITS

Recommendation.—That the Committee consider requiring uniform cost-reporting procedures on a national basis as a condition of participation in both Medicare and Medicaid. In the event that such a proposal is adopted and certified financial statements are submitted, the Committee should require the Social Security Administration to accept a desk-type audit or brief review as a "final"

audit. The Social Security Administration should reserve the right to make a random sample review of these audits in the manner in which the Internal Revenue Service makes these audits.

Opinion.—It is our thought that the adoption of such a procedure would result in substantial cost reduction for both Medicare and Medicaid in an area of program cost not directly related to patient-care. The Association believes, moreover, that such a procedure should result in sharply decreasing the inordinate and protracted delays which are now occurring in the final settlement of accounts for specific calendar years.

III. CERTIFICATION OF EXTENDED-CARE FACILITIES

We concur with the Staff of this Committee in its conviction that only those facilities should be certified which are in full compliance with those conditions of Participation for ECFs which are related to patient-care and services.

We think, however, that when an already existing facility fails to meet all of the Conditions related to the physical plant, certification of such facilities should be permitted only if the failure to comply fully does not threaten the well-being of the patient.

Newly constructed facilities, of course, should meet all of the standards.

Medicaid Skilled Nursing Home—Intermediate Care Facility Relationship

We think that there exists an acute need to clarify the definition of intermediate care. The statutory definition provides both a floor ("more than room and board") and a ceiling ("less than skilled nursing care"). The range between these two requires clarification.

The Association would urge the Committee and the Staff to consider the social components of care as an integral part of intermediate care.

On page 98 of the Staff's outstanding report, the statement is made that the intent of Congress was that "by definition, intermeditae care would cost substantially less than skilled nursing home care." Obviously, we would not quarrel with that statement as to the intent of Congress. Who better than this Committee and its Staff would know the intent of Congress?

However, we would raise the question whether given the broad range of care and services from that of more than room and board to less than skilled nursing care and given the equally broad spectrum of the physical and mental conditions requiring institutional care and living accommodations, intermediate care would by its intrinsic nature as distinct from its legislatve concept always result in a cost less than that of skilled nursing home care, let alone substantially less than the same. Perhaps, the overall cost of the program of intermediate care woud be substantially less than the overall cost of the skilled nursing care program. But perhaps this would not be true of the care required by a given individual recipient.

Moreover, the Association recommends that together with clarifying the nature of intermediate care, reimbursement for such care be made on the basis of "reasonable costs." With such a reimbursement formula the Association believes that intermediate care would take its place as a positive program of care and services of the aged equal to that of Medicare and Medicaid.

Institutional Utilization Review Mechanisms

The Association shares the concern of this Committee and its Staff over the widespread failure of the utilization review mechanism properly to function.

The Association firmly upholds the position that all potential conflicts of interest be removed from the utilization review procedure.

While the Association appreciates the need, in many instances, for ECF utilization review mechanisms to be outside the facility, it also believes that such outside mechanisms need not be universally required.

With more than three years experience at its disposal, the Bureau of Health Insurance should be able to determine whether or not an ECF utilization review committee opreates without real or potential conflict of interest and whether or not this committee enjoys a successful performance record. The Association is persuaded that in these instances of success, the Committee should be permitted to continue its work.

We concur in the Staff's recommendation that legislation be enacted which would remove any legal liability for decisions made during required utilization review and medical audit activity.

We would recommend that concomitant with the implementation of the Staff's recommendations concerning utilization review, consideration should be given to

strengthening the force of the utilization review committee's decisions. Many involved in the utilization review process believe that committee activities and their review by intermediary clerks stand in serious conflict, that only when the utilization review committee's decisions are given more serious consideration by SSA will activity on these committees have professional stature and dignity and will physicians lose some of their reluctance to serve on these committees.

VI. MEDICAID ADMINISTRATION

We are fully aware that the excessive delay in obtaining rules and regulations from the Department were not occasioned by the present Commissioner of MSA; nevertheless, it is essential that he take steps to prevent its reoccurrence and we would urge this Committee to determine if such steps have been taken and to insist on them, if they have not.

Towards the goal of improving the administration of Medicaid, there is merit in the Staff's recommendation that the Advisory Groups for Title XVIII and Title XIX be consolidated.

However, we are not certain at this point in time that the Intermediate Care Program should be brought under the purview of a Medicare-Medicaid Committee. This matter might better await the definitions required by the Intermediate Care Program. At that time, perhaps a need for a separate committee to consider intermediate care might emerge.

VII. OTHER AREAS OF ACTUAL AND POTENTIAL ABUSE IN MEDICARE AND MEDICAID

Recommendation.—We recommend that this Committee consider amending Section 1908 to prohibit a licensing board from having a majority of members derived from only one profession or one type of institution concerned with the care of chronically ill and infirm aged patients.

We further recommend that this Committee maintain a close scrutiny of the State programs to implement Section 1908. These programs are only now beginning to unfold as the deadline of June 30, 1970 approaches. As part of our testimony we are providing the Committee with copies of an AAHA publication: "Some Questions and Answers Relative to the Licensing of Nursing Home Administrators."

OPINION

It is our thought that a Board composed of a majority from any one profession or any one type of institution militates against the requirement that the Board be representative in its composition. Further, the presence of such a majority on the Board presents a danger which grieviously jeopardizes the ultimate intent of this Committee that long-term health-care administration would in time become a true health profession.

Long-term care is by its nature inter-disciplinary. Hence, the provision that the Board be representative of those disciplines whose skills are essential to long-term care was a wise provision. Representation on the Board of these various disciplines would markedly assist in the eventual professionalization of long-term care administration. A substantial majority from one profession or one type of institution, however, would seem to at least dilute the representative quality of the Board, if not render it suspect.

Mr. Chairman and members of this Committee, we thank you for permitting us this opportunity to testify today.

Senator RIBICOFF. Thank you very much.

Senator Williams.

Senator WILLIAMS. No questions.

Senator RIBICOFF. Senator Bennett.

Senator BENNETT. No questions.

Senator RIBICOFF. Thank you very much for giving us your time and your ideas, sir.

Mr. Morris Campbell, please.

STATEMENT OF JOHN PICKENS, GENERAL COUNSEL, AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY MORRIS D. CAMPBELL, JR., MEMBER, LEGISLATIVE COMMITTEE, AMERICAN NURSING HOME ASSOCIATION; AND DR. GORDON DAVIS, PHYSICIAN

Mr. PICKENS. Mr. Chairman and members of the committee, I am John Pickens, general counsel of the American Nursing Home Association.

On my right I have Mr. Morris Campbell, president of the Georgia Nursing Home Association, who will testify, and on my left, I have Dr. Gordon Davis, a physician of Georgia.

We wish to have Mr. Campbell's statement inserted in the record, Mr. Chairman, and he will just read from parts of it, in view of the time.

Senator RIBICOFF. Thank you very much.

Without objection, the entire statement will go into the record as if read.

Mr. CAMPBELL. Mr. Chairman and members of the committee, I am the owner and administrator of the Colony House, a 143-bed nursing home in Fitzgerald, Ga. Colony House is fully certified as an extended care facility.

The association appreciates this opportunity to appear before this subcommittee of the Senate Finance Committee, and, as its spokesman today, I want to congratulate publicly the committee for its wisdom in putting together the staff which has produced the report titled, "Medicare and Medicaid Problems, Issues and Alternatives," to which our testimony today will be directed.

Frankly, we are pleased to report that we find ourselves in agreement with most of the staff report's findings and with most of its recommendations.

The American Nursing Home Association feels strongly that those providers of service and those beneficiaries of these services who deliberately abuse the programs should be exposed and punished.

There is no place in the health care system and, particularly, there is no place in the nursing home field for the fast-buck operator, the financial manipulator who would use the nursing home as a basis to get rich quick at the expense of the ill and the aged who are entrusted to his care.

But I would caution that deliberate abuse not be mistaken for honest errors and human misunderstandings because of the morass of confusion that has surrounded both programs, and especially the medicare program.

You already have received testimony from a number of fiscal intermediaries noting the difficulty in reviewing benefit claims under the present guidelines that ECF care be continuous skilled nursing services rather than frequent or intermittent skilled nursing care.

I think you can readily see the predicament in which the nursing home or extended care facility finds itself. The home provides care following the basic guidelines of the law only to find that patient benefits are denied retroactively. The home is left holding the bag, so to

speak, and faced with the prospect of having to try to collect for the services from either the patient or his family or absorbing the cost itself.

Physicians—already under pressure from families to keep the elderly patient in the hospital as long as possible because there is no daily deductible until after 60 days of care in a hospital while a deductible is made after only 20 days in an ECF—are put under additional medical and economic pressures not to transfer the patient to an ECF for fear that benefits will be denied retroactively. And I must point out that there have been few, if any, retroactive denial of hospital stays on medical necessity under past operations of the medicare law.

While the extended care facility is being financially hurt by retroactive denial, it is the patient, his family and ultimately the taxpayer who are being shortchanged by this operation of the present law.

To remedy the situation which results in overutilization of hospitals and extensive retroactive denials in ECF's, we recommend reducing the present pressures being applied by social security on fiscal intermediaries to deny ECF benefits retroactively by—

(*a*) Having the law amended to establish a minimum number of covered care days in ECF's by categories of illness so that the patient, his family and his physician know that if ECF care is ordered there will be no question of retroactive denial for at least a specified number of days.

(*b*) Congressional definition of noncovered care to minimize present confusion over custodial care.

(*c*) Providing for determination in the hospital, whenever possible, of the need for ECF care and physician certification with utilization review of ECF care set after seven days in an ECF or prior to the end of the period specified for categories of illness—under "a."

(*d*) Relating more closely to average lengths of stay, the number of "free" days in both hospitals and nursing homes, but in no case allowing more free hospital days than ECF days.

(*e*) Limiting the number of allowable hospital days and ECF days to 45 and 50 days with an additional 45 to 50 days established for a certified catastrophic illness ECF days to 45 to 50 rather than the present 90 and 100 respectively, and encouraging earlier transfers by allowing patients to exchange 1 hospital day for 2 ECF days even 3 since ECF costs are only about one-third the costs of hospital days.

On this latter point, we would like to urge this subcommittee to consider making the stays available on a calendar-year basis. We urge this change because of our experience with the SSA's definition of "spell of illness" which has denied all but one benefit period to tens of thousands of elderly patients, who must reside in a personal care or intermediate care facility because of their age and/or physical economic conditions. They can never break their "spell of illness" for 60 days because of this residency. Whether or not the calendar year basis is accepted, we would urge the committee to insure that SSA not use stays in an intermediate care facility as a means of denying the beginning of a new "spell of illness" as SSA now does.

While we agree basically with the requirement for full compliance, we would urge caution aganst taking a rigid, unflexible stance. The problem of full compliance is one not entirely within the control of the owner-administrator. In many areas, particularly in small towns and rural areas, there simply are not adequate supplies of qualified consultants, much talk about improving inadequate professional and sub-professional labor pools, little has been done nationally to increase and to train and educate the personnel so sorely needed.

On the issue of distinct part certification for medicare, the association agrees with the staff that if a facility certifies a distinct part, such distinct part should in fact be set apart distinctly.

I think we would be less than candid, however, if we failed to point out to the committee that as one moves into this problem area as it concerns multiple use of facilities for ECF care, skilled nursing home care and intermediate care, the problem becomes more difficult.

There will be and there are now some cost differentials primarily because of varying requirements for professional personnel and ancillary services. But requirements for safety, environment, plant and equipment and for auxiliary unskilled personnel are virtually the same, and in some cases, demands for activity and social program may offset savings in costs attributed to more intensive nursing and rehabilitative care in higher level facilities or distinct parts of facilities.

The level of care cost differences actually will hinge in many cases on needs for ancillary services such as drugs, physical and other therapy programs, and the cost of additional licensed nursing personnel.

We are committed to support of a prospective rate payment program and feel that such a program must be established by Congress now. The program must provide incentives for creating efficiency and cost savings by allowing the facility to share in such savings. Such a program of establishment, through negotiations, of a prospective rate, must take into account adjustments for unusual circumstances, such as increases in minimum wages. We know, as does the committee, that retrospective reimbursement provides little incentives for cost savings, particularly if it is linked in any manner to a "cost-plus" program which is the way medicare reimbursement started.

While it is a salutary effort to recommend interest penalties to help speed payments to providers and to assure realistic interim rates, it is important to note that these latter rates are not always deliberately set high. In many cases interim rates have proved high because retroactive rulings and regulations have changed the rules of the game after the game had been played. In such cases, no penalties should be inflicted.

As a matter of fact, with 1967 and 1968 audits still incomplete one can easily understand how a facility may owe substantial sums to the Government for these years and even for succeeding years under rules they did not know were to apply. It is imperative that to insure success of the program that an equitable means be established for repayment of these sums to the Government.

We also feel that to insure the validity of the interim rates of a cost-basis program, intermediaries should be required to conduct simple desk audits and that where this is done no penalties be exacted in terms of interest rates if no change in the interim rate is ordered.

We agree that States should be allowed to determine their own payment formulas within reasonable Federal guidelines under medicaid and even under the ICF programs for the categorically needy since the States have a major financial interest in these programs. Because of the differences found between different facilities in various States and in various fiscal setups of the States, establishing a ceiling based on title XVIII could destroy effective incentives for cost savings under other programs.

We already know, from experience, as expressed in part by the staff report, that cost-conscious States in some cases have reclassified facilities on a wholesale basis from skilled nursing homes to ICF's, and, in like manner, provided for wholesale downward reclassification of patients not because of patient needs but because of the State's attempt to reduce program cost even at the risk of patient welfare. An administration proposal, now part of legislation moving through Congress, to cut skilled nursing home care by use of the Federal dollar limitation will encourage such disregard for a patient's needs to an even greater extent and we are hopeful that this committee is aware of the consequences of the legislation.

The administration proposal to reduce drastically Federal contributions for skilled nursing home care under medicaid after 90 days is not only unrealistic in terms of patient conditions, ages, and known lengths of stays required; it is also unfair to the States which have been forced into the medicaid program, and enticed into certain aspects of the program.

The result of such a move will be to force better nursing homes out of the program for fear they will be put into a position, in effect, of malpractice. It will be a high road of care for those whose families may be able to make up the difference and a low road for the poor. It will mean disaster for the medically needy whose care in an ICF is not eligible for Federal matching funds and a lower level of care for the categorically needy whom the State will transfer to an ICF regardless of his medical need after 90 days to get full Federal funds under the title XIX matching formula.

In short, we believe this proposal is a pennywise, pound-foolish proposal that will reverse the trend of recent years toward improvement of the health care of the aged, the convalescent, the chronically ill and the poor.

As we have said on a number of occasions, the physician truly is the key to the ultimate success of the health care program. But we are just as convinced that SSA has obligations, not only to providers of services, but to the beneficiary and the public generally, which it has failed to fulfill. For example, SSA has refused to assume its responsibility to tell beneficiaries that while services they receive may be authorized by the physician, and by a utilization review committee, ultimately the beneficiaries personally may be billed for the services because of the present policy of making retroactive determinations of noncover care. It is time someone let the public know what it is not entitled to as well as what it is being provided.

The same is true for providers of services. I am certain that many fine facilities would not have geared up for medicare if they had known that costs they incurred in 1967 would be denied under SSA rules established in 1969 or 1970 and applied retroactively. The rules of the game have not been very clear.

Finally, let me note that medicare is the only major Government program where Government is regulating an industry or field—and also procuring all of Government's requirements from the provider that it is regulating—where the rules, regulations or other actions of the Government agency is not subject to administrative or judicial review.

Accordingly, we propose that direct suits against the Secretary be allowed to be brought in the U.S. district court where the facility is located or in the U.S. District Court in the District of Columbia and where the amount of the claim is $10,000 or more and has been pending for 90 days.

Thank you.

(The complete prepared statement, above-referred to, follows:)

TESTIMONY OF THE AMERICAN NURSING HOME ASSOCIATION ON THE MEDICARE AND MEDICAID PROGRAMS

Mr. Chairman, and members of the Committee, I am Morris D. Campbell, Jr., owner and administrator of the Colony House, a 143-bed nursing home in Fitzgerald, Georgia. Colony House is fully certified as an extended care facility.

I have been in the nursing home field since 1958 and am the immediate past president of the Georgia Nursing Home Association, president of the Georgia Chapter of the American College of Nursing Home Administrators and a member of the Legislative Committee of the American Nursing Home Association.

The American Nursing Home Association is a nonprofit organization representing both proprietary and nonproprietary long term care facilities in 48 states. Its membership at the end of 1969 was 7,400 facilities representing some 425,000 beds. Since the present year began, an additional 400 facilities with a bed capacity of nearly 20,000 have become members.

The association appreciates this opportunity to appear before this subcommittee of the Senate Finance Committee, and, as its spokesman today, I want to congratulate publicly the committee for its wisdom in putting together the staff which has produced the report titled *Medicare and Medicaid Problems, Issues and Alternatives* to which our testimony today will be directed.

The report is a commendable effort to bring into focus many of the problems confronting not only state and federal governments, but providers of service, direct beneficiaries of these two programs and ultimately the taxpayers themselves.

The association at its past two annual conventions has seen its House of Delegates call for major overhauls of both the Medicare program and the Medicaid program. We are in agreement with the staff report that both programs are in financial trouble and that they have contributed sharply to the skyrocketing cost of health care in this country.

The pouring into the nation's conglomerate health care system of billions of dollars of new Federal funds and the complexity of the programs and the constantly changing regulations and interpretations of the law not only have added to the inflationary spiral of health care, but also have resulted in costly confusion and uncertainty for all providers of service.

ANHA leaders, early in the game, challenged estimates of the first year costs of ECF benefits and asserted that even using Federal projections of utilization, the costs would be $175 million or more rather than the $25 million to $50 million estimates given congressional committees by government actuaries.

We noted at the time that the requirement for a three-day hospital stay and the offer of 60 days free care in a hospital compared with only 20 in a nursing home would result in undue family pressures on physicians to keep patients in costly hospital beds when they could be adequately cared for in extended care facilities. And we truly believe today that improved, realistic and innovative utilization of nursing homes and extended care facilities for both short and long term convalescence and rehabilitation offers tremendous savings in health care costs for not only government but private citizens and other third party payors.

So you see, we are in agreement with the staff finding that "to simply expand the Medicare and Medicaid programs as now constituted and operated would, we believe, compound costs and confusion."

Frankly, we are pleased to report that we find ourselves in agreement with many of the staff report's findings and with many of its recommendations.

We feel strongly that unless major reforms are undertaken by the congress with regard to these programs they will falter, and we believe there are those who not only are looking forward to their failing but would actually hasten that failure.

To the contrary, we do not believe that the answer to the complex problem of delivering health care services to all the citizens of this Nation—the problem of getting the most for the health care dollar—can be, nor will be solved by wrapping the health care system up in one big government package.

The American Nursing Home Association feels strongly that those providers of service and those beneficiaries of these services who deliberately abuse the programs should be exposed and punished.

There is no place in the health care system and, particularly, there is no place in the nursing home field for the fast-buck operator, the financial manipulator who would use the nursing home as a basis to get rich quick at the expense of the ill and the aged who are entrusted to his care.

But I would caution that deliberate abuse not be mistaken for honest errors and human misunderstandings because of the morass of confusion that has surrounded both programs, and especially the Medicare program.

That confusion has been compounded by changing regulations, many of them retroactively applied by SSA through physical intermediaries; by the failure of SSA to issue a complete provider's manual; by the complexity of the accounting and reimbursement systems; by the inability of participants in the extended care program, in particular, to reach final settlements on benefit claims until literally years after these services have been provided through the high-cost, time consuming "overkill" audit system, and by retroactive denials by fiscal intermediary offices of claims that patients, their physicians and utilization review committees felt would be covered.

These frustrations have forced many excellent facilities either to withdraw from the Medicare program and many more to reduce their participation in it to a minimum. Social Security's own estimates as reported in several publications put the number of withdrawals last year at some 500 facilities.

The confusion over what is covered service and what is non-covered service under the extended care benefits has resulted not only in extreme hardships for nursing homes, which provide the vast majority of the extended care beds for the Medicare program but, more importantly, hardships for the ill aged and their families and increased costs for the program itself.

Let me quote from an article that appeared in the Wall Street Journal of April 8, 1970, by Jim Hyatt, a staff reporter:

"Mrs. Henry Nelson, 77, spent 31 days in a Milwaukee hospital last year undergoing treatment for a stroke. Medicare paid the entire bill.

"Then a social worker at the hospital suggested that Mrs. Nelson be moved to a nursing home where she could receive round-the-clock nursing care and the therapy she needed to learn to walk and talk again. Medicare can pay for up to 100 days of such 'extended care.'

"But it didn't work out that way for Mrs. Nelson. 'After she was there two months, Medicare wrote me and said they weren't going to pay the bill,' says her husband, a retired foundry worker. 'I owed them $1,616.75.'

"The Social Security Administration, which administers the Medicare program of national health insurance for the elderly, had decided that Mrs. Nelson needed only custodial or minimal care rather than skilled nursing care. Mr. Nelson, who receives $130 a month in Social Security benefits, is paying the bill off at $50 a month. His wife, still a convalescent, is now at home."

In that same article, Mr. Hyatt reported that Social Security records showed the denial of ECF benefit claims had more than trippled from a rate of two per cent in 1968 to 7.2 per cent in the last quarter of 1969.

I think it imperative that as we discuss extended care benefits under Medicare, Part A, we realize we are discussing an aspect of the program which accounts for only about seven per cent of the cost of the program compared with 92 per cent of the cost which goes to hospitals.

And I think it just as imperative that we realize that with hospital per diem costs already at the $100-a-day mark in some metropolitan areas, the extended care facility and the nursing home with its various levels of care and classification from skilled care to intermediate and personal care, can serve and should serve as an effective safety valve on the rising cost of institutional health care.

However, the present Medicare law and its application as interpreted by SSA, is working against the potential which the long term care facility holds for most effective utilization of institutional facilities and for getting the most for the health care dollar. To substantiate my point that there has been an over-zealous denial of ECF benefits, let me cite a few statistics based on SSA's own reports of claims.

In October 1969, approved claims for patients cared for in extended care facilities (upon certification of need by a physician after a hospital stay of at least three days and within 14 days of discharge from the hospital as the present law stipulates) were down 35 per cent from the same month in 1968. While approved claims for October 1968, totalled 82,693, a year later approved claims had dropped to 53,137 for the month.

The total amount of the claims dropped some 33 per cent from $29 million to $19.4 million.

At the same time hospital claims were reduced only slightly from $317.4 million in October 1968, to $315.7 in October 1969.

We believe that a speech given by Senator Moss of Utah on April 10, 1970 on the floor of the Senate goes far in illustrating some of the problems which we are discussing today. The Senator refers to "the step-by-step dismantling of the medicare nursing home program." We have attached, as an exhibit to our testimony, extracts from that speech.

Numerous examples of retroactive denial could be brought to you, but let me simply refer to testimony given by Frederick W. Offenkrantz, Medical Director of the New Jersey Rehabilitation Care Foundation, Cranford, N.J., on May 7 before the subcommittee on long term care of the Senate Committee on Aging, in which he protested retroactive cutoffs numbering 50 in one year and 18 in one day by the New Jersey Blue Cross, fiscal intermediary serving that non-profit facility:

"1. Every cut-off was made despite referrals from general hospitals whose utilization review procedures embody referrals to E.C.F.'s. Further, in every instance a referring physician from a general hospital certified to the need for E.C.F. care. These patients are involuntarily sent to us from their hospitals in accordance with the Medicare rules.

"2. Cut-offs were made with total disregard to the certification by the attending physician at the Cranford facility as to need for E.C.F. care, plus a pre-admission review by the Administrator, the very capable and experienced Director of Nursing, and by the Medical Director.

"3. The utilization Review Committee of this non-profit community facility is comprised of, among others, a physiatrist, the medical director and a practitioner of many years standing not admitting patients to this facility. In each instance of retroactive cut-offs, this committee had certified to the necessity of additional E.C.F. care, within the guidelines from the Social Security Administration as best we can interpret them, plus our mutual judgment.

"4. In many cases, no portion of the patient's chart, except for an initial check list was requested or reviewed by the individual making these cut-offs, which of course, should be medical judgments.

"5. In every instance the cut-off was made retroactive up to as much as seven weeks from the date of our notification, sometimes this was to the date of the patient's admission to this facility. In several instances the date of cut-off was actually after the death of the patient.

"6. In many instances the attending physician has flatly refused to order discharge of patients following these cut-offs. Because of the severity of the patients' illnesses, these physicians felt strongly that discharge would constitute malpractice. I must call your attention to the fact that if this constitutes malpractice on the part of the attending physician, it constitutes malpractice on the part of the intermediary in so ordering, contrary to our combined medical advice. Since many of these victims come from poor areas, many being inner-city ghetto residents from Newark and Elizabeth, New Jersey, they cannot afford the charges; and as a non-profit facility, are deeply in debt because of those denials which are made long after we, in all good faith and honesty, have rendered the service.

"7. Despite repeated efforts, no appeal to reason, no appeal for review and no appeal to professional judgment or humanitarian need has been entertained by the New Jersey Blue Cross Plan or the Social Security Administration.

"8. In no instance, during my almost two years of tenure as the Medical Director, has a physician from the intermediary or the S.S.A. contacted me

regarding a cut-off. This, in my opinion, constitutes a serious defect in the entire program. It permits unnamed persons to effect virtually a life and death decision on these patients, whose requirement for additional care is certified to by referring physicians, treating physicians, consultants, and utilization review physicians at this extended care facility."

You already have received testimony from a number of fiscal intermediaries noting the difficulty in reviewing benefit claims under the present guidelines that ECF care be that requiring continuous skilled nursing services rather than frequent or intermittent nursing care.

I think you can readily see the predicament in which the nursing home or extended care facility finds itself. The home provides care following the basic guidelines of the law only to find that patient benefits are denied retroactively. The home is left holding the bag, so to speak, and faced with the prospect of having to try to collect for the services from either the patient or his family.

Physicians—already under pressure from families to keep the elderly patient in the hospital as long as possible because there is no daily deductible until after 60 days of care in a hospital while a deductible is made after only 20 days in a nursing home—are put under additional medical and economic pressures not to transfer the patient to a nursing home for fear that benefits will be denied retroactively. And I must point out that there have been few, if any, retroactive denial of hospital stays on medical necessity under past operations of the Medicare law.

While the extended care facility is being financially hurt by retroactive denial, it is the patient, his family and ultimately the taxpayer who are being shortchanged by this operation of the present law.

To remedy the situation which results in overutilization of hospitals and extensive retroactive denials in ECFs, we recommend reducing the present pressures being applied by Social Security on fiscal intermediaries to deny ECF benefits retroactively by:

a. having the law amended to establish a minimum number of covered care days in ECFs by categories of illness so that the patient, his family and his physician know that if ECF care is ordered there will be no question of retroactive denial for at least a specified number of days.

b. congressional definition of non-covered care to minimize present confusion over custodial care.

c. providing for determination in the hospital, whenever possible, of the need for ECF care and physician certification with utilization review of ECF care set after 7 days in an ECF or prior to the end of the period specified for categories of illness (under a.).

d. relating more closely to average lengths of stay the number of "free" days in both hospitals and nursing homes, but in no case allowing for more free hospital days than ECF days.

e. limiting the number of allowable hospital days and with additional 45 to 50 days established for a certified catastrophic illness ECF days to 45 to 50 rather than the present 90 and 100 respectively, and encouraging earlier transfers by allowing patients to exchange one hospital day for two ECF days or even three since ECF costs are only about one-third the costs of hospital days.

On this latter point, we would like to urge this subcommittee to consider making the stays available on a calendar year basis. We urge this change because of our experience with the SSA's definition of "spell of illness" which has denied all but one benefit period to tens of thousands of elderly patients, who, must reside in a personal care or intermediate care facility because of their age and/or physical economic conditions. They can never break their "spell of illness" for 60 days because of this residency. Whether or not the calendar year basis is accepted, we would urge the committee to insure that SSA not use stays in an Intermediate Care Facility as a means of denying the beginning of a new "spell of illness" as SSA now does.

The staff report goes into some detail on Medicare ECF standards as being "high on paper" but criticized the allowance for certification of facilities for "substantial compliance" where plans were underway to bring them into full compliance.

While we agree basically with the requirement for full compliance, we would urge caution against taking a rigid, unflexible stance. The problem of full compliance is one not entirely within the control of the owner-administrator. In many areas, particularly in small towns and rural areas, there simply are not adequate supplies of qualified consultants, even qualified RNs and licensed prac-

tical nurses. And, despite much talk about improving inadequate professional and sub-professional labor pools, little has been done nationally to increase and to train and educate the personnel so sorely needed.

I think we should also be aware that there is a need to have ECFs as close to the patient's family as possible and frankly with well over 5,000 hospitals certified automatically for Medicare, we feel there is a need for maintaining at least the present number of certified ECFs, and even more in some areas where there are shortages of available beds.

On the issue of distinct part certification for Medicare, the association agrees with the staff that if a facility certifies a distinct part, such distinct part should in fact be set apart distinctly.

I think we would be less than candid, however, if we failed to point out to the committee that as one moves into this problem area as it concerns multiple use of facilities for ECF care, skilled nursing home care and intermediate care, the problem becomes more difficult.

Of course, if as we anticipate and hope for, the Congress comes up with a prospective rate plan for payment of providers of services, some of these problems may be mitigated.

I note this at this time because I fear that there are some in government who see major savings by forced down-grading of patients from ECF to skilled nursing homes to intermediate care homes.

There will be and there are now some cost differentials primarily because of varying requirements for professional personnel and ancillary services. But requirements for safety, environment, plant and equipment and for auxiliary unskilled personnel are virtually the same, and in some cases, demands for activity and social program may offset savings in costs attributed to more intensive nursing and rehabilitative care in higher level facilities or distinct parts of facilities.

The level of care cost differences actually will hinge in many cases on needs for ancillary services such as drugs, physical and other therapy programs, and the cost of additional licensed nursing personnel.

We are committed to support of a prospective rate payment program and feel that such a program must be established by Congress now. The program must provide incentives for creating efficiency and cost savings by allowing the facility to share in such savings. Such a program of establishment, through negotiations, of a prospective rate, must take into account adjustments for unusual circumstances, such as increases in minimum wages. We know, as does the committee, that retrospective reimbursement provides little incentives for cost savings, particularly if it is linked in any manner to a "cost-plus" program which is the way Medicare reimbursement started.

Many of the problems providers have had with Medicare have stemmed from the unreasonableness of the so-called reasonable cost; the attempt to force homes to average costs (attributable to the Medicare program only) throughout the facility to reduce Medicare costs; the attempts to include under routine nursing services, costs that should be attributable to a specific patient's care when it is exclusive to that patient and the complexity of the accounting and auditing system.

While it is a salutory effort to recommend interest penalties to help speed payments to providers and to assure realistic interim rates, it is important to note that these latter rates are no always deliberately set high. In many cases interim rates have proved high because retroactive rulings and regulations have changed the rules of the game after the game had been played. In such cases, no penalties should be inflicted. As a matter of fact with 1967 and 1968 audits still incomplete one can easily understand how a facility may owe substantial sums to the government for these years and even for succeeding years under rules they did not know where to apply. It is imperative that to insure success of the program that an equitable means be established for repayment of these sums to the government.

We also feel that to insure the validity of the interim rates on a cost basis program, intermediaries should be required to conduct simple desk audits and that where this is done no penalties be exacted in terms of interest rates if no change in the interim rate is ordered.

We agree that states should be allowed to determine their own payment formulas within reasonable Federal guidelines under Medicaid and even under the ICF programs for the categorically needy since the states have a major financial interest in these programs. Because of the differences found between different facilities in various states and in various fiscal set-ups of the states, establishing a ceiling based on Title XVIII could destroy effective incentives for cost savings under other programs.

We already know, from experience, as expressed in part by the staff report, that cost-conscious states in some cases have reclassified facilities on a wholesale basis from skilled nursing homes to ICF's, and, in like manner, provided for wholesale downward reclassification of patients not because of patient needs but because of the state's attempt to reduce program cost even at the risk of patient welfare. An administration proposal, now part of legislation moving through Congress, to cut skilled nursing home care by use of the Federal dollar limitation will encourage such disregard for a patient's need to an even greater extent and we are hopeful that this committee is aware of the consequences of the legislation.

The Administration proposal to reduce drastically Federal contributions for skilled nursing home care under Medicaid after 90 days is not only unrealistic in terms of patient conditions, ages, and known lengths of stays required; it is also unfair to the states which have been forcd into the Medicaid program, and enticed into certain aspects of the program.

The result of such a move will be to force better homes out of the program for fear they will be put into a position, in effect, or mal-practice. It will be a high road of care for those whose families may be able to make up the difference and a low road for the poor. It will mean disaster for the medically needy whose care in an ICF is not eligible for Federal Matching Funds and a lower level of care for the categorically needy whom the state will transfer to an ICF regardless of his medical need after 90 days to get full Federal funds under Title XIX Matching Formula. In short, we believe this proposal is a penny-wise pound-foolish proposal that will reverse the trend of recent years toward improvement of the health care of the aged, the convalescent, the chronically ill and the poor.

I might add parenthetically here that we do not look favorably on the term "reimbursement." We feel that the government and any other third party payor should think in terms of "payment for services rendered" to their beneficiaries.

The American Nursing Home Association supports voluntary areawide health planning and has so stated in its Declaration of Policies adopted November 6, 1969 in Houston, Texas. On this particular subject, let me quote from that document:

"Recognizing the urgent need of conserving the national health dollar while expanding and improving currently available services, the American Nursing Home Association supports programs of voluntary areawide health care planning. ANHA urges nursing home owners and administrators to insist upon such planning and to take an active part in its establishment and operation.

"In addition. the American Nursing Home Association opposes any plan that would deny a proprietary or nonproprietary nursing home facility control over its own capital, e.g., legislation to require funding of depreciation allowances, or the pooling of such funding when the item being depreciated, be it building or equipment, has not been acquired through free, non-repayable government grants."

Senator Anderson and staff members will recall our previous statement on this matter when the Reverend August J. Hoeger, Jr., of the Good Samaritan Society, a nonprofit church oriented organization with more than 100 nursing homes, pointed out that his organization put its own resources on the line in financing captial improvements and certainly did not feel the depreciation funds should go into any central pool unless those capital improvement monies originally came from the government. I would add, we were appreciative of the Senator's agreement with that stand at the time.

As we have said on a number of occasions, the physician truly is the key to the ultimate success of this or any other health care program. But we are just as convinced that SSA has obligations, not only to providers of services, but to the beneficiary and the public generally, which it has failed to fulfill. For example, SSA has refused to assume its responsibility to tell beneficiaries that while services they receive may be authorized by the physician, and by a utilization review committee, ultimately the beneficiaries personally may be billed for the services because of the present policy of making retroactive determinations of non-covered care. It's time someone let the public know what it's not entitled to as well as what it is being provided.

The same is true for providers of services. I am certain that many fine facilities would not have geared up for Medicare if they had known that costs they incurred in 1967 would be denied under SSA rules established in 1969 or 1970 and applied retroactively. The rules of the game have not been very clear.

Finally, let me note that Medicare is the only major government program where government is regulating an industry or field (and also procuring all of

government's requirements from the provider that it is regulating) where the rules, regulations or other actions of the government agency is not subject to administrative or judicial review.

In *Aquavella* v. *Finch* (the Glen Oaks Case), 306 F. Supp. 860, 863, (W.D. N.Y., 1969), Judge Henderson, June 30, 1969, the Court held that a "provider" of services under the Medicare Act can bring an action for judicial review of a determination of the Secretary in two instances ONLY, (1) where the Secretary determines that the provider is not eligible to participate in the Medicare program, and (2) where the Secretary terminates the provider's contract and holds the provider not to be further eligible. To the same effect are several other Federal court decisions.

The Medicare Act requires that in promulgating regulations (1) that the Secretary (a) consult with national organizations and (b) refer the proposed regulations to the Health Insurance Benefits Advisory Council (HIBAC), and the Administrative Procedure Act requires (2) that the proposed regulations be published in the Federal Register, and (3) comments solicited before it is finalized, codified and enforced.

The original "Conditions of Participation for Extended Care Facilities", as well as the original "Principles of Payment" went through this required process. However, during the past 3 years, over 1,000 state agency letters, intermediary letters and other instructions, written and oral, have been promulgated, drastically modifying the "Conditions of Participation and Principles of Payment", and with few exceptions, not one of them has been issued pursuant to the due process requirements of the Medicare Act or the Administrative Procedure Act.

In other words, the industry or national associations were not consulted, the proposed changes were not referred to HIBAC and were not published in the Federal Register for comments before implementation. To add to such arbitarary action, countless important changes and amendments were made retroactive for periods in excess of two years.

For example, actions of the Defense Department adversely affecting a government supplier are subject to review by the Armed Forces Board of Contract Appeals as well as by other Boards of Contract Appeals. The Defense Department does not begin to regulate its government suppliers to the extent that the Department of Health, Education and Welfare and the Social Security Administration do. Yet it has a review process. In addition, it should be noted that the Medicare Act give the Secretary more discretionary power to issue rules and regulations than in almost any other piece of Federal legislation. Certainly, some review of his actions should be allowed. Especially since he has delegated so much of his authority to the Social Security Administration as well as to the various divisions of the Department such as the Medical Services Administration and others.

The Administrative Procedure Act of almost every state allows judicial review of actions of the State Health or Welfare Commissions. Recently, the Court of Appeals for the State of California (Third Appellate District) in *California Association of Nursing Homes* v. *Spencer W. Williams, Administrator of the Health and Welfare Agency of California*, Cal. App. 2d, March 24, 1970, held that a provider in California could sue the state where the state agency had not followed procedural due process in fixing reimbursement rates for nursing homes.

In *Catholic Medical Center of Brooklyn* v. *Rockefeller*, (U.S.D.C. E.D. N.Y.), No. 69–C–641, 305 F. Supp. 1268 (1969), a three judge statutory composed court (required because constitutionality of state law was raised) held two hospital providers under Title XIX could maintain an action against the State of New York where the "State Plan" and state law were in conflict with Title XIX of the Social Security Act as amended.

It seems anomalous that the Federal Government should not allow judicial relief in a section of an area where most states do, and even where the Federal Government allows it in all other sections of the area.

In a procurement situation where the agency acts as legislator, prosecutor, judge and jury all combined, without any restraints except its own, arbitrary action is not discouraged.

Accordingly, we propose that direct suits against the Secretary be allowed to be brought in the United States District Court where the facility is located or in the United States District Court in the District of Columbia and where the amount of the claim is $10,000 or more and has been pending for 90 days.

Exhibit A

Extracts from Speech of Senator Moss (Democrat, Utah) Delivered in U.S. Senate on April 10, 1970

I have alluded to the step-by-step dismantling of the medicare nursing home program and I want to document that at this point in my speech. My point is that even if the dismantling was well intentioned with the ascribed purpose of saving Federal dollars that were finding their way into opportunistic pockets, the tearing down of what could be an effective, viable and beneficial program was done in the most arbitrary fashion available. Let me make clear my belief that most of the physicians in the medicare program are honest and have endeavored to assist our senior citizens to the best of their abilities. Those who have taken the advantage of the system, be they physicians, or providers or druggists are in the narrow minority. I regard it as unfortunate to penalize the majority for the actions of the few.

One of the first and most major changes instituted in the medicare nursing home program was that medicare would not pay for patients who were merely custodial. Even if they needed the extension of the kind of care that they were receiving in the hospital, they would not be paid for by medicare unless they were deemed to have rehabilitative potential. By this edict all terminal patients were excluded at once with great savings to the Government.

Another major step was intermediary letter No. 371 which decreed that beyond the requirement of having rehabilitative potential, a patient to be compensible must fall within the narrow category of "skilled nursing care" and covered care as defined within that letter. From a medical and clinical point of view the definition of skilled nursing care is artificial, if not nonsensical, comments Dr. Michael B. Miller, medical director of the White Plains Center for Nursing Care:

"The implementation of the present distorted definitions of skilled nursing care propounded by the Social Security Administration can only result in the strangulation in midstream of a good socio-medico program, in complete defiance of the intent of Congress, and the will of the People. Synthetic definitions related to skilled versus custodial care can only be fictitous and misleading. The concept that the more disabled, the more ill a chronic patient becomes, the less need for skilled care, is erroneous and cannot be supported by medical and nursing principles. Indeed, the more handicapped and disabled, the more skilled services are needed, not the contrary attitude which currently prevails."

Dr. Miller cited a few examples of what he means as follows:

First. Feeding a patient is an unskilled service under current regulations and is not compensable and yet a common problem among nursing home residents is loss of weight. Many patients lose up to 50 percent of their body weight during their stay in a home. "We don't know how to feed patients today because nobody has ever studied it. I have noticed that some nurses can feed certain patients but not others. I'd like to know why."

Second. Giving drugs currently is a skilled service unless given by mouth. According to Dr. Miller this is nonsensical because there are a great many patients who are emotionally sick or with organic brain damage who should not be entrusted to take the medication themselves which is what happens today. Further, science has been working these many years for an alternative to the needle and when we finally succeed, it suddenly becomes an unskilled service. "It is just as easy to give an overdose of drugs by mouth as it is by injection."

Third. The insertion of catheters is a covered so-called skilled service, but the care and treatment of the patient from then on is currently classified as unskilled service. He said:

"The use of catheters is frought with dangers because there is no way that it can be accomplished without putting infection in the body. Just raise the receptable of the in-catheter up to bed level and I will guarantee you the patient will have fever and chills within 36 hours. Mishandling in the slightest degree can lead to death and yet this is not classified as a skilled service."

With these new directives the function of the intermediary insurance carrier in the system changed from its passive administrative role to a new aggressive function of determining what is covered care and the amount of compensation, measuring eligibility requirement and judging compliance with social security directives. Naturally administrative costs of the system increased in 1969 in view of the intermediary's new, function. According to the Finance Committee the

1968 administrative costs for medicare was $104 million in 1968. The total cost of administration in the first 9 months of 1969 was $102 million or only $2 million less than the entire administrative costs the year before.

* * *

But there is more to the story. On February 2 of this year HEW and Social Security announced new accounting rules designed to restrict payments to profit-making nursing homes and hospitals under both medicare and medicaid. The new rules tighten up procedures for the calculation of depreciation, a significant reimbursable cost. Nursing homes will now have a depreciation base of the lowest of three figures—actual cost, fair market value or replacement cost less depreciation. A second change would prohibit the use of accelerated depreciation by operators of new facilities or facilities expanded to include medicare. In this context I recall the statement of Merlin A. Reeder, president of the Utah Nursing Home Association, who complained of the difficulty in receiving payment from medicare and the attendant delay:

"We can't go on living on our depreciation, we have to have a few dollars to be able to render the same service to patients again today and tomorrow."

It looks as if Mr. Reeder and others like him will not even be able to count on the guarantee of that minimal amount representing depreciation of their facilities.

It will also be recalled that on July 1, 1969, the third anniversary of medicare, the decision was handed down to eliminate the 2-percent "bonus" above actual cost. The deletion was announced in customary fashion—abruptly and by administrative fiat. Little matter that Commissioner Ball had indicated that the 2-percent—1½ percent in the case of proprietary institutions—allowance was not a bonus but it represented a finding that some costs were present that were not otherwise expected to be specifically provided for in the costs accounted for and apportioned to medicare. Commissioner Ball told the Finance Committee:

"I would not agree that the 2 percent was over and beyond cost. It was over and beyond defined and accounted-for-cost."

Reportedly the change will save the Treasury some $100 million in fiscal year 1970. The chilling effect on those operators who might wish to stay in the medicare nursing home program is obvious.

In addition to all these changes medicare nursing home providers are soon to face the same probing General Accounting Office which brought out sensational revelations with regard to the C–51 and F–111.

One last directive formulated in late 1969 announced just a few days ago deserves mention. This directive from SSA commands the intermediary to review salaries of all nursing home personnel with particular emphasis on the salaries paid to administrators. The basis for this was a reference in the Finance Committee hearings indicating that some administrators had paid themselves $75,000 a year.

The changes instituted by the administration which directly affects the pocketbook of the elderly are as follows:

First. In September 1969 the President submitted to Congress a proposal calling for an additional $136 million in medicare payroll taxes in addition to tax increases already scheduled under the Social Security Act.

Second. By January 1, 1969, the deductible, the initial amount payable by the patient, was raised from $40 to $44. Effective January 1, 1970, the deductible has been raised to $52 with the promise that it would go up to $84 by 1974.

Third. The part B portion of medicare that the patient pays to get coverage for physicians' charges was raised 32 percent, to $5.30 a month. This measure will raise some $600 million annually.

The record then is clear: in the short space of 1 year the elderly faced three substantial increases: taxes, fees, and premiums in support of the medicare program. All these increases were imposed notwithstanding the fact that the elderly received reduced services at least within the narrow context of the availability of the medicare nursing home.

That the directives issued since January 1969 have had a restrictive effect on the use of the nursing home cannot be questioned. Neither physicians nor nursing home operators could predict or guarantee payment by medicare. For this reason, and because all the directives were imposed retroactively with the obligation to pay back payments received from medicare, more than 500 nursing homes have dropped out of the medicare nursing home program. According to Gaylord Shaw who wrote the story for the Associated Press, this is but a prelude to things to come.

What should be made clear at this point is that all of these directives issued in 1969 and earlier this year by the Social Security Administration to the intermediaries have been given retroactive effect. Claims which matured for expenses occurred in 1967 and 1968 have been denied on the basis of a list of criteria announced in 1969. Even worse, a nursing home operator may have received final payment for a patient who received services in 1967, and now in 1970, 3 years later, there are issued new directives which when given retroactive effect require the administrator to "pay back" the money he has received. Small wonder that nursing home administrators complain to me that accepting a medicare patient is about as unpredictable as putting a quarter in a slot machine.

Senator RIBICOFF. Thank you, sir.

Mr. PICKENS. Mr. Chairman, there is one small area he did not cover, if I may mention it, and this is with regard to the problem of the waiver of licensure of practical nurses.

I think you have had testimony before that after July 1, 1970, under the present skilled nursing home regulations, only licensed practical or licensed vocational nurses, who are graduates of the State-approved school can act as a charge nurse in a nursing home, with minor exceptions.

Of course, medicare conditions of participation have a similar provision.

The association has had, I guess, eight or nine meetings with Health, Education, and Welfare since 1966 in an attempt to solve this problem. Many waivered nurses are as well qualified, and some better qualified, than many recent graduates of State-approved schools, and we have consistently asked HEW to classify them by education, background, experience, and rate them, and the Department has refused to do so.

Some waivered LPN's are individuals who start out to take a registered nurse's course, and who dropped out at the end of 1 or 2 years of RN training because of financial or other reasons, and then they took the LPN test by waiver and passed it and so, of course, received their license by waiver. Others graduated from school a year or more prior to the time the State had a program of approved LPN's, and still others, of course, work as practical nurses, and after years of experience were allowed to take the State examination, and they passed it, and they were licensed by waiver.

This committee in 1967 instructed the Department to do proficiency testing and, as far as we know, nothing has been done about this problem to date.

Our association, along with the National Association of Practical Nurses education and service prepared, with the aid and assistance of five registered nurses, three of whom had been or were on State boards of nurse examiners, and three of whom had been directors of nursing service in large hospitals, and together we spent a considerable time preparing a 64-to-72-hour refresher course for LPN's.

On completion of this course the waivered nurse would be given a national examination which, if she passed it, would remove this waiver as far as the Department of Health, Education, and Welfare was concerned.

Now, as far as we know, this was the only course or program ever submitted to the Department in all these years. But we were turned down flat on this.

We feel that this regulation should be suspended until the Department classifies LPN's and determines their proficiency.

We further feel that the Department should be required to follow this up by allowing training in approved courses or programs so that these nurses can come up to standard because otherwise we are going to lose a large number of waivered LPN's or waivered licensed vocational nurses as of July 1 of this year.

Senator RIBICOFF. Thank you, sir.

Mr. PICKENS. Thank you, sir.

Senator RIBICOFF. Senator Bennett.

Senator BENNETT. No questions.

Senator RIBICOFF. We thank you, gentlemen. Would you please remain. The staff would like to ask you gentlemen some questions.

STAFF. Dr. Chase, in your testimony you made much of the team approach in the medical schools. Is the team approach common to virtually every medical center and is that the approach taken to private and institutional patients alike?

STATEMENT OF DR. ROBERT A. CHASE—Resumed

Dr. CHASE. It may be; yes, sir. There is a similar team approach, for example, as described this morning.

STAFF. Do you mean for all of the teaching institutions? Apparently you are speaking for some 330.

Dr. CHASE. That is correct, and I would say the team approach or some variation of the team approach is common to most of these. I can't tell you precisely what the statistics are.

STAFF. And the care provided by the team is identical in the case of institutional patients and private patients in most teaching institutions?

Dr. CHASE. We have attempted to eliminate that separation between institutional patients and private patients because I am not quite sure what you mean by an institutional patient.

STAFF. Well, the patient who presents himself to the institution or is referred to you from the clinic as opposed to the private patient who is seen by the physician in his office, and that physician happens to be on the staff of your hospital. Is the care provided identical in terms of the attending physician's service to the private patient and the institutional patient in all of the teaching institutions you represent?

Dr. CHASE. I would like to be completely clear again on what you consider an institutional patient. I will ask for clarification.

If I may, I would ask whether a patient who goes to the Mayo Clinic is considered a private patient or an institutional patient.

STAFF. We were speaking really of the majority of your teaching hospitals, not the Mayo Clinic, not Ochsner. We are talking about——

Dr. CHASE. The Mayo Clinic is a teaching institution.

STAFF. But they are not the majority. They charge, as I understand it, a separate flat charge for all medical care for each patient.

Now that isn't typical of a majority of the institutions you represent, is it?

Dr. CHASE. Unfortunately, there is no typical teaching institution, and that is one of the points which we have tried to make. We are suggesting that legislation be responsible to the wide variety of modes of delivery of care and modes of teaching in the various institutions.

STAFF. In terms of the predominant mode, is the care which the

private patient receives as opposed to the institutional and service patient in the majority of the institutions you represent identical, and provided in the identical fashion?

Dr. CHASE. It varies quite sharply from institution to institution and I find it almost impossible to give a single answer to that question.

STAFF. Who organizes and arranges the hospital team?

Dr. CHASE. The organization within a teaching setting traditionally is organized along specialty lines and, therefore, the head of a department of surgery or pediatricts, of medicine, of psychiatry, generally has this responsibility.

STAFF. Within the hospital.

Dr. CHASE. He organizes the team. Again it varies from institution to institution, because the departmental structures vary quite considerably from institution to institution.

STAFF. Are you essentially contending that one member of the team be singled out for fee for service payment and that everyone else be compensated for on a cost basis? What effect would that kind of "discriminatory" attitude have on team spirit.

Dr. CHASE. That is precisely what is being suggested in the community teaching hospital. Since there is such a team in these institutions where the private practitioner brings his patient to the community teaching hospital and there is, in fact, a team made available to him consisting of interns and residents. They operate as a team, and the billing for professional services is done on behalf of the attending physician.

STAFF. In medical cases where the patient in general has a private physician, does the attending physician, as a rule see the patient more frequently than the supervisory physician who is an attending physician?

Dr. CHASE. There is wide variation but I would suggest that an internist, for example, and that is the specialty you suggest, who actually resides full time in the institution and has his offices there is more likely to see the patient more frequently than is a person who has an office across town.

STAFF. Are you familiar with any of the cases which GAO has turned up in some teaching hospitals where a hospital has assigned four attending physicians to one patient and billed for them, in one case simultaneous for 50 consecutive days?

Dr. CHASE. I am not familiar with that instance, and I certainly wouldn't condone it, unless there was a precise and identifiable service to the patient on the part of each of those individuals on each day and they were billing for these consultation services. I would not consider all four of them as attending surgeons.

STAFF. Where the care is arranged and organized within the hospital setting, as it is, why shouldn't the Congress follow Dr. Hall's recommendation and reimburse the hospital for the team on an actual and equivalent cost basis.

Dr. CHASE. I am not opposed to that notion as one possible means of compensating for care offered to a patient. I believe it probably could be offered at a cost equivalent to or less than that delivered in the nonteaching sector.

STAFF. You mean under fee for service.

Dr. CHASE. Yes, sir.

STAFF. We don't want to be misunderstood.

Dr. PATTERSON. I think there is a comment that might well be made here. If there is not a prevailing practice for hospital charges, and if university medical schools, because of their particular method of delivering care, put all of this into part A, then the per diem for that particular group would be calculated on a different basis than what prevails for other institutions, it would have to be accepted as being high and considered on that basis. The danger is that there have been suggestions from time to time that there should be some equalization of costs, and if one group of hospitals has built into part A the fees for professional services and another group didn't this would cause certain inequities.

Dr. CHASE. May I respond to that also. I think there is a misunderstanding here. I did not understand the sense of your question in quite the same manner. Your question suggested to me the proposal that no matter what the source, whether it be part A or part B of medicare was it possible for an institution to go to a cost basis and somehow audit the total costs of medical care that have been paid out of medicare aside from whether it came from part A or part B, is that correct?

STAFF. No, not quite. Where the care is organized and arranged by the hospital in an institutional setting and by the hospital's medical staff, why shouldn't the Government adopt Dr. Hall's recommendation and reimburse on a costs or costs equivalent basis for the services of all members of the team.

Now, obviously your organization wants fee for service.

Dr. CHASE. No, that is not quite true, sir. I reject that as a notion. We are not necessarily in favor of fee for service as the only mechanism by which costs could be made. The notion of going to a cost payment as you have suggested is one of the techniques that I think should be experimented with in selected teaching institutions. That is the only place that it can be determined.

STAFF. Fee for service experimentation and cost experimentation both.

Dr. CHASE. Yes.

STAFF. As you know, large numbers of Veterans' Administration physicians work in both VA and non-VA hospitals. Under VA regulations such doctors are not permitted to serve as attending physicians in non-VA hospitals or bill for such care for medicare and medicaid patients.

Do any of you gentlemen know, or have you heard, of any teaching hospitals which have billed medicare or medicaid for services of Veterans' Administration physicians?

Dr. CHASE. I have not heard of such cases of physicians who work full time for the Veterans' Administration. Under conditions where they work part time for the Veterans' Administration they may also work part time for the university. Under those circumstances I see no reason why they should not be reimbursed for that time that they utilize in serving either private patients or medicare patients.

STAFF. Specifically, have any VA physicians services been billed for at Stanford, to your knowledge?

Dr. CHASE. Excuse me, have any VA patients?

STAFF. The services of VA physicians who also work part time at Stanford, have any of their services been billed for by the school or by the hospital.

Dr. CHASE. I would have to say that to my knowledge there has not been such a case for a person who works full time for the Veterans' Administration.

STAFF. Do you gentlemen know of any other VA physicians serving as attending physicians in teaching hospitals?

Dr. CHASE. I have heard the question raised, sir, by the central office of the Veterans' Administration, not in reference to——

Dr. STONE. I wouldn't want to guarantee it hasn't happened in Albuquerque.

STAFF. Precisely how does each medicare beneficiary in a teaching hospital recognize, acknowledge and contract with a specific supervisory physician to whom he becomes liable for substantial sums, several hundred dollars or more.

Dr. CHASE. I can answer——

STAFF. Not at Stanford.

Dr. CHASE. I can answer for the setting I know best which is Stanford University. The patient arrives at Stanford just as he might arrive at Mayo Clinic. He may come without an identified physician or he may come referred specifically to a faculty member. If he is referred to a specific faculty member I presume he would fall into the category you characterize as private. If he comes unassigned to Stanford University and appears at the surgical clinic, he is assigned to a full time faculty surgeon who introduces himself and his team and makes it clear to the patient that he will be cared for by this team. That he is the responsible physician under these circumstances, but that under certain circumstances parts of his care will be under the jurisdiction of individuals on that team.

STAFF. Now, you are testifying for AAMC. Would you say that is typical of all of its membership?

Dr. CHASE. I can't say that it is true for all of the membership. Once again it comes back to the point that there is great variation and a great variety of systems for delivery of care. I would hope that all systems would finally come to the Stanford technique.

STAFF. Dr. Hamilton, at Hartford Hospital, for example, has your staff been billing, for supervisory services under medicare?

Dr. HAMILTON. The physicians in private practice, if they have medicare patients, have been billing. The physicians who are full time on the hospital roll have been covered under part A. This is the sort of program that Dr. Hall was describing today. In our institution we are not intimately connected with a medical school although we are one of the affiliating hospitals with the University of Connecticut School of Medicine.

This plan works very well. I think from what Dr. Chase is saying that you see the development of the team approach more likely to be found throughout the institution and the hospitals that are intimately connected with medical schools.

STAFF. Were you satisfied with Dr. Hall's recommendation? Would that be helpful to your institution, the salary equivalent approach?

Dr. HAMILTON. Yes, and as Dr. Chase said, I think this is one of

the ways to do it and in our particular institution I think it would work all right. But that doesn't mean it should apply to every institution.

STAFF. Is there anyone here from a school other than Stanford, which is rather atypical.

Dr. CHASE. But great nevertheless. [Laughter.]

Dr. PATTERSON. I am not sure whether one can say this is atypical or not.

STAFF. It was not a reflection on the quality of the school but just in terms of the pattern of billing.

Dr. PATTERSON. Essentially the University of Connecticut School of Medicine is a developing medical school. We have been involved in patient care now for 3 years. We have just had two classes of medical school, but basically the plan that we are operating under is very, very similar to that which Dr. Chase described for Stanford, and if he is atypical then we are also atypical.

I think that there are a number of points that come up here which also indicate the variety of situations that may exist across the country.

I also have difficulty with this definition of private versus institutional patient.

In Connecticut we feel that there probably are no longer institutional patients as such. The welfare department, if the patient happens to be on welfare, pays fees for a year, they pay usual and customary fees for medicaid patients, and the patients could get their care from any hospital or any physician they chose to go to. In this sense the definition of institutional versus private patient is disappearing.

At the University of Connecticut, we see only one kind of patient, they are all treated the same way.

STAFF. Has AAMC made any effort to determine precisely what each of its member institutions are doing. Do you know what the patterns are in your organization or are you essentially speaking for your individual institutions.

Dr. CHASE. We are speaking for our institutions and we have analyzed this to some extent. In our conversations with the SSA it was felt that there probably were and this is a guess, a half dozen to ten Standard systems for the delivery of care within teaching settings. We happened to have described three of those today. One was described by Dr. Hall. I described one for Stanford. You heard the system at the Hartford system and the system at the University of Connecticut.

There is a good deal of crossover in all of these systems but the one comment I would make is that all of us have a feeling that institutional patients as described here are disappearing from the scene, and we consider this one of the virtues of the medicare legislation since it seems to be hastening the disappearance of institutional patients. I myself would not, if given the choice, want to be an "institutional patient" in the sense that the old fashioned ward patient or service patient or any of a number of different designations which have been used in the past for the indigent population of the United States.

STAFF. Our information was that in a majority of teaching hospital centers the distinction still exists between the institutional patients and the private patients.

Dr. CHASE. Well, there is going to be——

STAFF. Is that true. That was the information we had?

Dr. CHASE. Yes, but you must recognize, I believe, that we were starting at the time that medicare was initiated, with a whole host of institutions that had such institutional patients. Those institutional patients, I am glad to say, are disappearing in the sense that I just described. And they are all becoming one class of patient. They are all sick people.

STAFF. Then the private physician, who is on your staff and has a private patient, his fees or reimbursement will also go to the school or the hopsital? Is that what you are saying will be the pattern?

Dr. CHASE. No.

STAFF. Or will he keep the fee for his private patient and with respect to the medicare patient, the fee will go to the school?

Dr. CHASE. I doubt that when a private physician who maintains an office in the city and carries the overhead that goes with such an office, and he is not offered a position on the university faculty but has all of the advantages of the interns and residents when he brings his patient to the university institution, is likely to respond favorably to the notion that he ought to turn his fee over to the medical school also.

STAFF. He is going to respond favorably?

Dr. CHASE. No, he is unlikely to respond favorably to that notion.

STAFF. Then you are saying in one case the fee goes this way and the other it goes that way.

Dr. CHASE. By the physicians choice.

STAFF. Isn't it true that some of the medical staffs make it a condition that fees must be assigned for service patients.

Dr. CHASE. Well, let me corect that by saying that in some institutions all fees for professional services are collected by the institution in the attending physicians name. That is by choice of the physician. If it were more palatable for him to accept the fees personally and make a gift to his institution in order that he could achieve this kind of reimbursement that would be acceptable, but it is interference with a system that already is in operation and probably the most progressive and liberal system among schools of medicine.

STAFF. Isn't it true however, that a number of institutions require the physician to assign his fees for service patients to the institution or to a fund?

Dr. PATTERSON. That is true, and——

And this is the understanding under which they accept employment under those circumstances.

STAFF. I think the essense of this is the distinction that if they are all receiving the same care nonetheless they money isn't receiving the same treatment.

Dr. PATTERSON. This is very similar though to places such as the Mayo Clinic.

Dr. CHASE. Once the money is received by the practicing physician or surgeon it seems to me up to him what happens to the money. He may wish to use it for some personal purpose, he may want to give it to his undergraduate school. He may wish to invest it in the stock market or he may wish to make it a gift to his school of medicine.

In certain circumstances, as has been mentioned, one of the terms of employment, such as in the full-time medical school institutions, is that such fees will be turned over to the school of medicine.

STAFF. Even with part-time staff I believe that is done in some cases, and that fees for service patients must be turned over. As a matter of fact there was one medical school in the area which said that they would increase substantially the stipend paid to their part-time staff if they developed at least three times that amount of fees from medicare and similar patients.

Are you aware, also, of the fact that where the physician voluntarily assigns fees to the school that there are some tax consequences; that that is considered income to him and subject to the charitable contributions limitations? Have you made all of your members aware of that?

Dr. CHASE. Oh, yes, anyone who works in a full-time university institution is fully aware of that.

A report on individual earnings at the year endings is furnished to each individual so he fully recognizes what his contribution is to the institution during that 1-year period.

STAFF. That isn't always true, Doctor. We had quite a few Cook County physicians who told us they didn't realize that many thousands of dollars had been paid for services which they in many cases said they had never rendered.

Just as a matter of information how much did Stanford Medical School receive in Federal research grants last year, do you know off hand, Doctor.

Dr. CHASE. I am sorry I can't give you the exact figure. It was a considerable sum for research.

STAFF. How much do the medical schools generally subtract for overhead?

Dr. CHASE. Our school subtracts somewhere in the neighborhood of 57 percent of salaries only, not of the total research grant. But should a faculty member or a research worker in the laboratory receive salary, close to 50 percent of that is withheld as overhead.

STAFF. Is that general on all grant funds?

Dr. PATTERSON. I would like to correct the terminology a little bit. It is not withheld. This is an additive sum which the Federal Government puts on as overhead on top of the grant to provide for the overhead which is calculated by federally determined accounting methods as to what the percentage should be.

Dr. CHASE. May I make another comment, too, for the record, and that is that in our own area the university does, in fact, have an overhead cost of somewhere in the neighborhood of 50 percent to 50 plus percent. At the same time in our own city there is a private research institute where research grants are also made, the Stanford research institute, and I know that the overhead costs to such institute runs clearly much higher, a hundred percent, 125 percent of salary because built into that there is a research and development cost which seems to be approved by the Federal granting agencies.

STAFF. That finishes all the questions we have. It is very difficult, as has been pointed out, to find out what is in between Stanford and some of these others.

Dr. CHASE. For your use, either on or off the record, we would like to offer our services to your staff for continuing discussion of the

dilemma we find ourselves in in dealing with the complex problems of the attending physician in the teaching setting.

There is a good deal of misunderstanding.

(Off the record.)

STAFF. Thank you very much.

Dr. CHASE. Thank you.

STAFF. Could we get the nursing home people here. Thank you. Are you gentlemen concerned over the tremendous growth in chain and conglomerate operations in the health care field?

STATEMENT OF JOHN PICKENS AND MORRIS D. CAMPBELL, JR.—Resumed

Mr. CAMPBELL. Are we concerned?

STAFF. Yes, sir.

Mr. CAMPBELL. Certainly we are concerned and our association has gone on record with very much interest in comprehensive health planning as to the number of beds in certain areas, and things of this type.

STAFF. Do you feel that there have been any problems posed for your members through the rapid growth of the chains and conglomerates in recent years.

Mr. PICKENS. Well, I suppose this is certainly true with the change. I guess it is generally known that some of the chains approached the association with the idea that they have a larger voice in the association, and have some autonomy in the American Nursing Home Association and, of course, when our executive board turned them down this same group formed the National Council.

STAFF. The National Council?

Mr. PICKENS. For Health Care Facilities.

STAFF. Those were the witnesses who were here this morning.

Mr. PICKENS. I think the first witnesses this morning, yes, sir.

STAFF. Should the Government pay full costs to a facility which is certified with deficiencies or should a method be used whereby less than full costs would be paid with a rate determined by the number and times of deficiencies. That is a suggestion made by the Louisiana, Arkansas, Ohio and Wisconsin nursing home groups.

Mr. PICKENS. I would support that type of arrangement. I recall some of their testimony in some of the areas of the deficiencies. I think they had some suggestions about the consultants be supplied by the State agency or by some other mechanism and, of course, this, as Mr. Campbell mentioned, this in some of your smaller cities and smaller towns, I mean this is one of your primary deficiencies.

STAFF. Based upon the experience and reports of your members, are hospitals frequently keeping medicare patients longer than necessary instead of moving them to lower cost extended care beds?

Mr. PICKENS. I think that is true and I think you will find it probably happens during certain months of the year more often than other times of the year, probably from May, June, July and August and through that period, but we certainly, our members of ECFs have constantly complained about the patient not being released to them, and I think that many of them have said that at least in the area of probably 10 to 15 percent of these retroactive denials, the reason that they were later considered non-covered care was the fact that they stayed in the hospital too long.

We had, as a matter of fact, not to go into this in any detail but there are two or three items I might mention. We, at the end of last year, made a survey and I would say I think it is in five nursing homes, five ECF's, four of them were in this area and these were selected homes. They were Bethesda, Silver Spring, Marcel Convalescent, Potomac-Randolph Homes, and Davis Nursing Home in Denver, and we compared length of stays in 1968 during the months of April, May, June, July and August and the months of stay in 1969.

Now these are length of stays ECF patients in that facility as compared with the length of stays of those same patients in the hospital from which they came, and in just, roughly in one home during this 5 month period in 1968 the average hospital stay was 25 days. In 1969 the same 5 month period it was 28.1 days.

The ECF stay in 1968 was, averaged 44.6 days, and in 1969 the average was 31 days, and we will supply this to you, but the trend in these five cases and other cases that we have tried seems to be the same, that whereas your ECF length of stay is coming down, 1969 over 1968, that your hospital length of stay is going up.

Now the other thing I want to call to your attention is that the latest monthly benefit statistics issued by them, on old age survivors and disability and health insurance, this is dated April 15, 1970, in November of 1968, for example, you had 74,237 ECF claims that were paid. One year later in November of 1969 you had 40,792 claims or a drop of 45 percent of the claims in all ECFs throughout the country.

Staff. That could be a product of problems at the intermediary level apart from the patterns of care.

Mr. Pickens. It could be but let me finish this one thing.

Now in November 1968, the total amount reimbursed for these ECF claims is $26,498,000. In 1968, the amount reimbursed was $15,140,000 or a drop of about $11 million.

Now take short hospital claims, short stay hospital claims for November 1968, there are 492,873 approved. A year later they had a drop of 11 percent, this is November of 1969, 382,685 claims, and the total amount reimbursed for these claims in 1968 was $271,416,000, as opposed to November 1969 of $257,720,000.

In other words, less than one-eighth of the rate of drop that you had in ECF claims.

Now, I agree that in and of itself this doesn't mean anything but I think in connection with all these other figures that we have it shows that there has been a real crackdown on the ECF claims, noncovered care, retroactive denials, and this sort of thing, and there has not been any such in the hospitals.

Staff. All right.

What proportion of medicare reimbursement do you estimate is attributable to cost finding and other clerical expense beyond that ordinarily incurred by nursing homes?

Mr. Campbell. What percent?

Staff. That is right. Of your total reimbursement, how much is attributable to cost finding and other clerical expense which you don't incur with respect to your nonmedicare patients?

Mr. Campbell. You mean ECF costs not the auditing or intermediaries audit?

STAFF. You have auditing and cost finding presumably for all patients, but nursing home owners are saying medicare imposes additional loads. What is the proportion of that additional load.

Mr. CAMPBELL. I would say around 15 percent.

STAFF. 15 percent of your per diem costs is for cost finding and audit expense which you don't have——

Mr. CAMPBELL. I believe——

Mr. PICKENS. Dr. Davis here has three facilities in Georgia.

STAFF. Can you get those figures for the record?

Mr. PICKENS. We could supply it.

Mr. CAMPBELL. We could supply it.

STAFF. Fine, and you might be able to get it for some other areas also.

Mr. PICKENS. Right. Would you like it for different areas of the country.

STAFF. If you like.

(Information supplied at this point follows:)

GEORGIA CARE NURSING HOME, SYLVESTER, GA.

ESTIMATE OF EXPENSES FOR ANNUAL MEDICARE COST REPORT AUDIT

This estimate of Medicare Cost Report Audit for each Medicare patient day has been prepared at request of the Senate Finance Subcommittee on Medicare and Medicaid.

Intermediary Auditors (two) for time spent at Nursing Home. This does not include time spent working on these audits at the Home Office.

Intermediary Auditors expenses:	
90 hours per week for 3 weeks at $15 per hour	$4,050
Lodging (night), $15, Food (day) $10–$25 a day each for 15 days for 2 men	750
Intermediary Auditors travel expense $61 for 3 weeks	183
Regional intermediary review audit	600
Home office intermediary review audit	720
SSA review	700
Auditor for Georgia care	400
Bookkeeper time with intermediary auditor	200
Other employees with intermediary auditor	200
Total	7,803

This does not include cost of long distance telephone calls between the Nursing Home and Intermediary concerning the Audit. Neither does it include any cost for clerical help in typing letters, etc. concerning the audits.

Since it took the Auditors approximately the same number of days to complete the audits in each home the same cost figure is used in computing the estimated cost for each home. These figures do not show any expense charges to the audit for my time as Administrator.

I have taken the number of Medicare patient days for each home from the audits divided it into the estimated cost for the audit to arrive at the estimated cost per Medicare patient day.

Year	Medicare patient days	Cost per day
Georgia Care Inc:		
1967	1,996	$3.91
1968	3,095	2.52
1969	1,699	4.59
Georgia Care of Tifton, Inc:		
1967	1,801	4.33
1968	2,337	3.34
1969	2,162	3.61
Georgia Care of Albany, Inc:		
1967	3,321	2.35
1968	3,121	2.50
1969	1,470	5.31

Since our 1969 audit, Georgia Care Inc. has had a total of seventeen Medicare days. Using the cost figures of $7,803.00 the cost per Medicare patient day would be $459.00.

Yours truly,

H. G. DAVIS, Jr. M.D., *Administrator.*

STAFF. You seem to be saying that medicare is not paying enough, is that correct? Why then are you attracted to a field that doesn't pay enough.

Dr. DAVIS. I think most of us got into the field before medicare was born, and we didn't know that medicare was here until it bloomed forth in full force and, well, it was attractive, we read the reports and we did investigate and meet the requirements.

After our audits we found out the profits are not there.

STAFF. Did you borrow on your profits.

Dr. DAVIS. Pardon.

STAFF. Have you borrowed on your profits, if profits disappeared.

Dr. DAVIS. I am sorry.

STAFF. Did you borrow on your profits before they denied the reimbursements.

Mr. PICKENS. I think a lot of people, a lot of nursing homes, I think became certified and went into medicare for various reasons. Some of them took 5 to 10 percent medicare patients. I think they thought it was a prestige package to begin with to be certified as a medicare facility, and I think you will find that whereas the department says there are only 400 or 500 that have withdrawn from the program, I think you will find in almost every instance it has been phased down drastically in each home, and there are many ECFs that only took 5 to 10 percent patients that still don't want to be decertified. They would rather take a patient now and then and still be able to say they are certified ECFs. I don't think—we have tried to get the figures on the amount of people that, I mean the phase out, and it is almost impossible unless you take it on a home by home basis.

STAFF. For smaller nursing homes or those with low average medicare occupancy would you favor a reimbursement approach which accepted charges after sample audits of costs for comparable services and comparable facilities in the same area.

Mr. PICKENS. I think we would, yes, sir.

Dr. DAVIS. I, for one, have 244 beds. I have four patients as of June 1 on medicare, and in one of the homes of 58 beds we admitted about 10 days ago the first medicare patient since July of last year, and not that we reduced them but they just didn't meet the medicare requirements, didn't pass the tests.

Mr. CAMPBELL. I have 143 beds and I have two patients on medicare.

STAFF. Two medicare patients.

Mr. CAMPBELL. Yes.

Dr. DAVIS. I would be willing to accept the formula you approach.

Mr. CAMPBELL. I may say I have one.

STAFF. Last week, the Louisiana, Arkansas, Ohio and Wisconsin nursing home associations endorsed the staff recommendations for tightening up the requirements for qualification of ECF's, including the requirement of a separate nursing station. Do you agree with those State associations?

Dr. DAVIS. Speaking for myself, I think if they certified a distinct

part I think they should have a distinct part but as for my institutions, why they are all, the whole, they are totally certified, so it would make no difference. I would accept the formula that you propose there, the averaging out of the homes, you know, in the area to get a cost or reimbursements formula.

STAFF. I don't believe that was an averaging out within the homes. That was an averaging out among the ECF patients.

Dr. DAVIS. Area, of the area, that is what I meant to say, excuse me.

STAFF. But, Mr. Pickens, does the association support the distinct part recommendation.

Mr. PICKENS. Yes, sir.

STAFF. As you know, there have been quite a few abuses with respect to kickbacks in nursing homes, and associations have complained about it.

This is not to imply that it is typical but apparently it is widespread. In testimony of last week by various State associations they said it was widespread.

As one example, a closet is set aside as a drug storage area with a rental to be paid by the pharmacist based upon a percentage of the business done with the facility. Are you familiar with any of that?

Dr. DAVIS. I have heard of it but I have never been familiar directly with any of it.

STAFF. You mean with how it is done?

Dr. DAVIS. I have heard of it being done, yes, but as far as knowing anyone that has done it, I do not know personally.

Mr. CAMPBELL. Are you saying a pharmacist rents a certain portion of their place and carries on business and pays the administration for this.

STAFF. Yes, sir.

Mr. CAMPBELL. I dont' know of any. Like Dr. Davis, I have heard, I know, where there are some pharmacies that are owned by the nursing home.

STAFF. What do you mean, owned legally or as a figure of speech?

Mr. CAMPBELL. Pardon.

STAFF. Is that a figure of speech or is that literal.

Mr. PICKENS. They will have their own pharmacy.

Mr. CAMPBELL. They have their own pharmacies.

Mr. PICKENS. Registered pharmacist on duty. You are going to find, you know, a hard core, I suppose, in any industry or any field that are always going to look for the gimmicks where they can make a fast buck. I personally haven't heard of a situation like that.

Yes, as long as it is a fair one, an honest ones approach. I won't say we don't have members who have done that. I don't know, I just haven't heard of it.

STAFF. Do you believe there is a potential conflict of interest in physician ownership of a hospital or ECF in which he admits and treats his own patients; this is other than in a facility where the physician is a full-time administrator or medical director.

Dr. DAVIS. May I speak, sir, being a physician owner?

STAFF. Yes.

Dr. DAVIS. No, sir, I do not. As long as I—if a physician gives a dollars worth of service he should receive a dollars part of pay. If he didn't give it, it would be fraud and I think he should be dealt with

accordingly. But if he does the work then I think he should be paid, compensated.

STAFF. Mr. Pickens, you are an attorney. Do you think there is any potential conflict of interest in these situations?

Mr. PICKENS. Well, I suppose there is room for it and, of course, I have heard of situations in connection with utilization review and so forth. There is room for, I suppose, for those that are so inclined and want to take advantage of it.

STAFF. Should a member of a utilization review committee be permitted to have an ownership interest in a facility where nonowner committee members are available or other review arrangements can be made.

Mr. PICKENS. No, I wouldn't think so. I think utilization review has been talked a lot about by the department but then encouraging community utilization review, for example, and I use the case of Cincinnati where they contracted out for a nonprofit corporation that had a contract with the medical society and they did it on a more or less a coded number basis, they didn't know who they were, the physicians didn't know who they were, reviewing and they didn't have any interest in any of the nursing homes, and in this instance, of course, the department doesn't pick up the full costs. They just pick up, if they had 25 medicare patients and you have a hundred bed home they just pick up one quarter of these total utilization review charges even though, of course, even though you don't—you review medicaid patients, well even though the other 75 patients were not reviewed and the costs solely related to the 25 patients under SSA regulations, the administrative costs, for example they only picked up a quarter of it, and they have put out two regulations they have withdrawn them twice and where they proposed only to pick up their percentage, the percentage of their beds in their home for the physicians costs, but they have backed down on those twice so far.

So I think they are to blame for it. They encourage community utilization review which I think probably is most desirable and best, and yet they won't pay for reasonable costs for it, and I think this has completely, this has discouraged some of the best utilization review programs that they had in this country.

STAFF. Do you believe that, with respect to medicare, the present statutory regulatory requirements requiring institutional services, staffing and safety are adequate and proper, and if not what specific changes would you recommend.

Dr. DAVIS. In Georgia the requirements for safety, et cetera, there in Georgia are similar to that required by the State health department and fire marshal's office. I don't think there is much difference in Georgia in the State regulation or medicare regulations for those points you mentioned.

STAFF. Well, do you feel all of those are adequate and proper?

Dr. DAVIS. I do.

Mr. PICKENS. I think you have to take it probably on a State by State basis. I think it all depends on the State law. I mean, as you know ——

STAFF. In relation to medicare?

Mr. PICKENS. That is right. There are obviously some States that, where these requirements are no greater than medicare requirements

but I think in many, many States they are higher than the medicare requirements. I think the medicare requirements are probably the absolute minimum.

STAFF. Do you think that the title 19 fire safety requirements, which are more stringent, as I understand it than those of medicare, should be made applicable to medicare.

Mr. PICKENS. Well, I would say it is so inconceivable that the highest classification that the ECF should have lower standards than they have, for example, for intermediate care.

STAFF. You mean it is inconceivable but true?

Mr. PICKENS. It is inconceivable that the ECF standards would be lower, that is correct.

STAFF. Do you agree that each participating health care institution should fully meet the standards for medicare participation. That is barring minor deficiencies or brief waiver periods, for example, where you are one nurse short and you need 30 days or so to replace her. But in general does your organization believe that each medicare institution should be in full compliance with the standards.

Mr. PICKENS. Yes, in general with the qualification that you have stated, and we certainly don't support an ECF that 3 years ago had—were not in compliance and were certified and have done nothing about bringing themselves up to full compliance. I have forgotten what they called it at the time. Wasn't it substantial compliance and there was another category.

Dr. DAVIS. You mentioned there even minor variations there, such as the social worker requiring a master's, 2 years master's degree, those things are not major items, and I certainly think that the program should be practical and realize that you won't find in every small community a person with a 2 year masters degree in social work, and I think you should be practical enough to make some revisions for the areas that none are available in.

Mr. CAMPBELL. I would like for the State to provide some of these services which they have on physical therapists and consultants and things of this type. This would aid in certain areas.

STAFF. In other words, you endorse the recommendation again of the Louisiana, Arkansas, Ohio, Wisconsin groups that where the State agrees to provide the required consultants——

Dr. DAVIS. Where there is a shortage in certain services people who are there.

STAFF. Can Georgia get social workers with 2 years of graduate work.

Dr. DAVIS. We don't even have a college giving that kind.

STAFF. Well, thank you.

In accordance with the direction of the Chairman we will resume at the call of the Chair.

Mr. PICKENS. We will submit the information you asked for.

(Whereupon, at 5:35 the hearing recessed until Monday, June 15, 1970.)

MEDICARE AND MEDICAID

MONDAY, JUNE 15, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Clinton P. Anderson (chairman of the subcommittee), presiding.

Present: Senators Anderson, Long, and Williams of Delaware.

Senator ANDERSON. I have a short statement that I will read.

Today and tomorrow we will essentially conclude the series of hearings based upon the report of our staff on problems in medicare and medicaid.

Following completion of these hearings I anticipate that the Subcommittee on Medicare and Medicaid will submit a report to the full committee summarizing our findings as well as such recommendations for improvements in the medicare and medicaid statutes as we believe will enable those two worthwhile programs to better serve millions of Americans in more efficient and economical fashion.

Improved legislation would, of course, by itself not accomplish what needs to be done. We also need better administration of the laws and greater cooperation and understanding on the part of all concerned with the operation of medicare and medicaid. All of this is vital if the primary goal of medicare—helping 20 million older Americans meet their health care needs in a dignified and self-respecting fashion—is to be achieved.

In February, the committee heard testimony from the administration. In April, we heard from the carriers and intermediaries. In May, we took testimony from hospitals and nursing homes. Now we are going to hear from those who hold the key to medical care in this country—the physicians.

Our staff found substantial abuse and some fraud on the part of a minority of doctors and other practitioners involved in providing services under medicare and medicaid. Our earlier hearings this year augmented those findings of the staff. But today, it would appear more appropriate to look to the future. Problems of fraud and abuse will, in time, be dealt with appropriately and medicare and medicaid will be rid of those engaging in such practices.

We need, however, to concentrate on much more basic problems such as assuring that those on medicare and medicaid receive the right care in the right place at the right time. Solutions of those problems involve prevention of unnecessary and overutilization of health care facilities and services along with assurances that professional standards of health care obtain where necessary care is being rendered.

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Again, the key to solving these problems is the physician—he is the common element of control in all aspects of health care. He literally and figuratively has his finger on the pulse of these areas of difficulty and their potential solution.

It is my fervent hope that organized medicine—at every level—will lead the way through vigorous, positive and professional programs of reviewing the need for the quality of care provided patients covered under medicare and medicaid. I understand that the American Medical Association—along with other segments of organized medicine—recognize the need for professional standards review programs and has been working on means and methods of developing such programs nationally.

Such review programs, undertaken throughout the country and implemented effectively and fully on a professional basis, would negate any need for Government to consider alternatives. If medicine assumes the responsibility for review and means business—then it is no business for Government.

Thus, we welcome the representatives of organized medicine today recognizing their responsibilities as well as our own. Hopefully, through sincere cooperation plus a substantial amount of hard work, we can build for the future.

Will the representatives of the American Medical Association please come forward to the witness table and introduce themselves.

Dr. Dorman. I am Dr. Gerald D. Dorman, president of the American Medical Association. With me are Dr. Julius W. Hill of Los Angeles, Calif., president of the National Medical Association, Dr. Andrew L. Thomas of Chicago, Ill., is at my left, secretary of the House of Delegates of the National Medical Association. Dr. Russell B. Roth of Erie, Pa., speaker of the House of Delegates of the American Medical Association, and Mr. Bernard P. Harrison, director of the AMA Legislative Department is on my far right.

Senator Anderson. Please proceed.

STATEMENT OF DR. GERALD D. DORMAN, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY: DR. JULIUS W. HILL, PRESIDENT, NATIONAL MEDICAL ASSOCIATION; DR. ANDREW L. THOMAS, SECRETARY, HOUSE OF DELEGATES, NATIONAL MEDICAL ASSOCIATION; DR. RUSSELL B. ROTH, SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION; AND BERNARD P. HARRISON, DIRECTOR, AMA LEGISLATIVE DEPARTMENT

Dr. Dorman. As a matter of record, I would like to point to this presentation as a first in the history of the National Medical Association and the American Medical Association. This is the first time the two national organizations, representing most of the physicians in this country, have joined together to appear before a committee of Congress.

It makes good sense for us to sit together and speak with one voice. Our purposes and ideals are the same. Many physicians belong to both associations and both the American Medical Association and the National Medical Association work to improve health care. We are equally concerned with the problems of delivering good health care to all our

people and we share a mutual concern over the cost of delivering this care.

Mr. Chairman, we have agreed that I shall speak first for the American Medical Association. Dr. Hill will follow with a statement from the National Medical Association. All of us will then be available to answer any questions the committee may have.

Let me make it clear at the outset that no member of this committee and no member of either House of Congress is more aware of the problems, or more eager to see them solved, than the men at this table and the thousands of dedicated professionals we represent. Our strong recommendation to you, to the Congress and to the people of this Nation is that we approach these various problems as partners and not as antagonists; that together, we seek solutions and use our present resources to meet the current needs we see. Let us take forward steps, no longer using up precious time in negative exercises.

Senator Long. Might I just ask a question now. I may not be here later on to ask this question. There are some doctors in my State who are promoting legislation to try to assure that neither the Federal Government nor any agency of the government, including those administering medicare and medicaid, would be permitted access to anything other than the patient's name and his diagnosis.

Now, I take it that that sort of thing was prompted by some objection to what we think is essential if this program is to be at all efficient, and that is a review system.

Now, would that fall within what you are talking about in terms of a negative approach to the program?

Dr. Dorman. No, Senator, it would not.

We feel that the negative approach has been shown by saying that we have no system at all, that we are not taking care of anyone. This, we feel, is a negative approach. We feel that peer review is necessary and we have a program of peer review which we plan to submit at a later date. It will have to include more than just the name of a patient and the diagnosis because we have to get into the details of how the patient is taken care of.

Senator Long. It has been my understanding that the Louisiana medical and hospital associations are opposing that legislation. Nevertheless, here is a group of doctors trying to push legislation through the State legislature, to say that those operating hospitals and those trying to provide payment and care under medicare and medicaid would not be permitted to see anything other than that patient's name, identification number, and diagnosis.

It seems to me that is just a case of somebody trying to obstruct doing what I think, and what I assume you think, is in the patient's interest; that is, among other things, to provide for peer review, to see if that patient should be or should have been in that hospital for 3 days or 3 weeks.

Dr. Dorman. Senator, it is a question of the confidentiality of the records of the patients who come to us with their problems that the profession does not want to have disturbed by making these records available to any person who wants to go looking at something from the outside. We feel that another doctor or a set of doctors can look at these things, and give good judgment and keep this confidential. It is a question of the confidentiality.

Senator LONG. How about Blue Shield and the Government's carriers who are supposed to be reviewing the care and paying for it. Why shouldn't they have the opportunity to look and see what kind and duration of treatment the patient is getting—whether it is proper and whether we are getting proper return for our money.

Dr. DORMAN. They have to look at it but we would have their doctors looking at it rather than have it just opened to the public.

Senator LONG. All right. Assuming it is a Government-paid doctor, or a Blue Shield doctor who is looking to see whether the fellow should be in the hspital for 3 days or 3 weeks. Now——

Dr. DORMAN. May I say——

Senator LONG. What is wrong with that? Why shouldn't somebody, on behalf of the Government take a look at it, doctor or no doctor? Why should not some doctor who had some responsibility towards those of us who are paying for that care look at the procedures and the care and the progress of that patient under that care.

Dr. ROTH. Senator, may I say, perhaps since I am speaker of the house of delegates of the AMA, I am as fully aware as anyone of the full spectrum of opinion in every regard that we have in our association of over 200,000 physicians, and we have those, who have their own ideas about how things ought to be done.

But the fact remains that the American Medical Association and its constituent societies are really the originators of the principle of peer review and are those who have put it into practice and developed it over a number of years. We stand, as an organization representing the majority of physicians four squarely behind the idea that indeed the only equitable way of deciding the appropriateness of treatment, the adequacy of quantity, and the equity of the charges that may be made for medical work done is through the principle of full disclosure through peer review, and I think this must be the answer to your question as far as we as an organization are concerned.

Senator LONG. Well now, I appreciate that answer.

I don't mean I should look at it. But a doctor should through a peer review procedure, and see that the case is being handled properly.

Here these people want to pass a law to say that it can't be done. If that is the case it means in Louisiana that all of our fine people under medicare and medicaid wouldn't get it because someone would importune the State legislature to pass a very silly law that would negate what Congress had tried to provide to protect the patient and the programs.

In years gone by I supported the position of the American Medical Association with regard to medicaid and medicare. I would hope that with regard to this sort of proposal that your association would say that it is negative.

That is not trying to help anybody. That doesn't help with the problem at all.

Dr. THOMAS. Senator Long, I am Dr. Thomas of Chicago. I happened to have been one of the original physicians who helped implement the utilization review mechanism under medicare and have had considerable experience in Chicago and am at present the chief consultant in this area to the State of Illinois.

We would share with you that peer review is most vital and most important and the medical associations on both sides have not only

encouraged this but, as Dr. Dorman mentioned, the American Medical Association for some 10 years prior to medicare had effective peer.

I think what we are saying is that if there are professionals, both on the private and public level, there would be no problem in the peer review mechanism. The great fear that patients and physicians would have is that there would be any system instituted whereby nonphysician personnel would attempt to evaluate professional activity. Clearly it would not be a very proper situation.

Unfortunately and very regrettably in some sections of the country where there are carriers, insurance carriers, who have not put forth the kind of effort necessary to get effective cooperation from the profession, there are nonprofessionals attempting to evaluate medical problems.

We would hold and feel that as we move along with medicare, and hopefully changes under medicaid, the professionals, the Louisiana situation notwithstanding, would in general certainly not only promote but cooperate fully with establishing the kind of review mechanisms we have available.

Thank you.

Dr. Dorman. Mr. Chairman, allow me briefly to outline three such positive approaches the medical profession hopes to see the Nation pursue.

The first two relate to the cost of care and the difficulty many people have in providing adequate protection for themselves and their families against the economic consequences of disease and injury. The third is a way of assuring both scientific quality and economic reasonableness in the medical and health care people get, whether or not they are beneficiaries of Government financed programs.

Our first program would meet the problems of the title XIX medicaid program. Under our plan, each low-income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The protection would be theirs without expense or contribution since the cost of the program would be borne entirely by the Federal Government.

The second offers tax credits, on a sliding scale based on the tax liability of a family, for the purchase of qualified health benefits coverage. For those with moderate or higher levels of income, the program would provide cash incentives, through tax credits, to encourage them to protect themselves against major health care costs.

The third part of our program calls for a structured peer review mechanism, as Senator Long was mentioning, to insure high quality of care and to prevent abuses of the medicare and medicaid programs. You will recall that your staff in its report suggested that medicine regulate itself; that Government cannot do it. We agree and propose a program providing for professional review on matters bearing on reasonableness of charges for, need for, and the quality of services renedered by the provider of medical or other health services.

Our proposal, which we call "Medicredit," and copies of which have been furnished to the committee, is the result of years of careful study of existing mechanisms for delivering and financing health care, coupled with our close study of the Federal Government's ability to pay for a national health insurance program. It envisions improvements, extensions, and refinements of what we have already evolved

in this country, rather than radical replacements. The shortcomings of our system, whatever they may be, stem from the rapid, relatively uncontrolled growth of medical technology, the staggering increase in demand, and American compulsion to experiment, innovate and improvise in an atmosphere of freedom of enterprise and the competition of the marketplace. To a great degree, our difficulties stem from the success of our health care system rather than from its failures.

Mr. Chairman, we understand that the committee plans at a later date to hold hearings on the bill which was recently passed by the other body and which provides for changes to the medicare and medicaid programs. At that time, we will present our views on the bill as well as our suggestions for further improvements in our health care system. We will speak to the problem of developing sufficient health manpower to meet the ever-increasing needs of our people, we will speak to the need to guard against destroying the quality of health care by including unscientific cultists; and we will present in greater detail our "Medicredit" plan aimed at making quality health care available to all and, through peer review, maintaining costs and quality of services.

Now, Mr. Chairman, we would ask Dr. Hill to continue with our joint statement and present the additional views of the National Medical Association.

Senator ANDERSON. Dr. Hill.

Dr. HILL. Mr. Chairman and members of the committee, I shall begin my brief remarks today by pointing out that the National Medical Association has joined the American Medical Association in these hearings because physicians across the Nation, regardless of their color or other considerations, are united in their concern over the costs of health care; united in their efforts to bring the highest possible level of health to all Americans; and united in their determination to work together to resolve the problems in the delivery of health care.

I would like to bring to your attention, sir, certain facts which I believe are appropriate and which I believe that as president of the National Medical Association, I have a special competence to present. A large percentage of our members take care of the poor.

When we talk about health care for the poor, we are talking about a great number of the blacks of this Nation. There are others among the poor, too, but many of the disadvantaged, the deprived, or whatever euphemism you wish to use are black.

My people, in the ghettos of our cities and on the depleted land in rural areas, have less chance than whites of getting an education, of getting an adequate job and of living in a decent home. They suffer from more chronic diseases; they have shorter life expectancy; more of their babies die at birth or very shortly thereafter; and fewer of them even have the luxury of dying a natural death.

I want to see everything possible done to help my people, and the poor of all races, have a better life. Their sons, husbands and brothers are fighting and dying now in Vietnam, as they did in Korea and World War II. If the poor are to be asked to die for their country, I believe we should do whatever we can to make it possible for them to live for their country and contribute to its continuing growth.

In regard to their health care—on which I shall concentrate—the Government does not have to do the whole job. We ask only that the Government encourage the expansion of medical and health care, so that these people are included.

Mr. Chairman, this was not done earlier this year when the staff of this committee released a report which, by implication, attacked the very physicians working closest to the poor and treating them. Further, this report advocated the fees of these doctors be restricted—cut off at a certain level.

To those who read the entire report, there were a number of very complimentary things said about all physicians. But the primary message, the one seized upon by the press and broadcast across the country, appeared to be that any doctor earning a substantial amount of money from medicare-medicaid was somehow cheating both the Government and his patients.

It was bitterly ironic. To work 60 and more hours a week in the ghetto, and to be fairly paid was suddenly prima facie evidence of wrong-doing.

The report was also interpreted so that the blame for the rising costs of medicare-medicaid was directed at the physicians—and particularly those caring for the poor.

Therefore, we of the National Medical Association take strong exception. The implications and accusations of that report are grossly unfair. Gentlemen, it is difficult enough to get physicians to practice among the poor; you cannot gerrymander a district so that the "boundaries" of a ghetto will include a doctor's office. If these men, professionals committed to providing care, are to be subjected to irresponsible accusations for the size and success of their ghetto practices, it will very soon be impossible to find a doctor among the American poor.

Senator Long. Doctor, if I might interrupt you there. I have looked over a long list of doctors making over $25,000 from medicaid and medicare in my State and I didn't find a Negro doctor on the list. They were all white and they treated the wealthy as well as the poor.

While you may feel that it could have been regarded as being aimed at those who are working among negroes, or those working in the ghettos, it was not. Speaking as one who represents a typical State, it certainly wasn't that way in my State.

Dr. Hill. Senator Long, in my State there was a situation where there was a black doctor who was high up in the earnings, that is so far as money from medical practice are concerned, but it happens that this particular physician, who was one of those in my State, and who was in that high income group, happened to have been black. However, he was a pediatric cardiologist, a rare specialty to whom I send in possibly 15 or 20 patients a week because he was a rarity and yet he was criticized unfairly and unjustly, because he had a large practice. Because I was able to send people who otherwise could not have received medical treatment to that super specialist, and there is a child who by virtue of medicaid is getting the treatment and because we are able to send more and more of those children to this cardiac specialist, pediatric cardiologist, he is making more money. We can't condemn him, sir, because we are sending more and more and more people to him every day because he is a rarity.

Yet still we take those figures, sir, and we take that particular doctor and his name was blasted across the headlines in California. We all had to go to his defense, Senator.

Senator Long. You are sitting beside a spokesman for the American Medical Association. They undertook to discipline some of their members for what they believed was improper conduct.

In my State, I personally did not publicize the names of any doctors who were making large amounts of money because I didn't want to be unfair to anyone. However we have had situations where people have been prosecuted and put into jail for some things they were doing with some of these old people. I hope you would draft a letter to the committee and say "here are what we believe are irresponsible charges and accusations. Spell out chapter and verse, and I will try to see that it doesn't happen again.

The staff wasn't condemning the entire medical profession, and neither was the committee. What we want is to act where people are victimizing the patient and where they are victimizing the government. At the same time we want to commend those of you who are doing a fine job, and we want to work with you.

Senator WILLIAMS. Would you cite the part of the staff report which you feel was critical of your group.

Dr. HILL. Dr. Thomas will speak to that.

Senator WILLIAMS. On what pages do these references appear.

Dr. THOMAS. No, we cannot do it, Senator. The problem, sir, is that the media, which responded to a press conference by the staff——

Senator WILLIAMS. As Mr. Agnew has pointed out, we can't control the media. I gather you would feel as Mr. Agnew does that the media didn't interprete this right?

Dr. THOMAS. No, there was a list of names given out by the staff and the Social Security Administration.

Senator WILLIAMS. No, you are mistaken. Our staff did not give out any list of names. Now some of the various state welfare departments released names but I don't recall that our committee released any names.

Dr. THOMAS. No, in the State of Illinois, it was the people responsible for the administration of the medicaid program who identified physicians who earned over $25,000.

Senator WILLIAMS. But that was the State of Illinois, was it not?

Dr. THOMAS. But these are the men who were included in the group of physicians where apparently there was a target set that those earning over $25,000 income from the program would be investigated. The thing that didn't come out, which may be a problem with the media itself, is that in the community of East St. Louis where nearly 80 percent of the population is on welfare, it becomes obvious that nearly, at least, 80 percent of a doctor's practice is a medicaid practice and, therefore, virtually all of his income comes from the medicaid program.

But the implication should not be that here is a physician who is raping the program, when he is in fact serving in a deprived, depressed area which is one of the worst in the country, as our Senator Percy will tell you since he has been out there to look at this area. The way it comes out to the public is that here are a bunch of bandits who are raping the program. What we wish to submit is that our men are dedicated professionals working 80 hours or more per week, some of them, and the idea is that they are struggling to provide the care.

We still feel, however, that the Congress does have the responsibility of making sure the public dollars are spent wisely. We have the responsibility of trying to make sure that the public goal is the same as the goals in various segments of the society. All we wish to do is to

practice this medicine and extend this care to the people and we would feel that in meeting the responsibility of the Congress to encourage and insure that there is an adequate program that together we will make sure that these people are liberated to become contributors to American society rather than dregs upon it.

Senator WILLIAMS. Well, we have bent over backward to protect the integrity of the names and not make a blanket indictment. We got letters from the American Medical Association pledging their cooperation. They did discipline a few cases and we have been well pleased with the cooperation.

To my knowledge, neither the committee nor the staff have released names. However, some of the various State agencies did. Of course, we can't control what the State agencies did, nor can we control the media.

You apparently feel, as Mr. Agnew does, that the media doesn't quite interpret the report correctly. Sometimes we feel the same way.

But the point is, if there is anything in our report which you feel was unfair I wish you would call it to our attention because we do wish to be fair about it. There have been, I am sure you will admit, some abuses in this program.

Dr. THOMAS. Right.

Senator WILLIAMS. If there is abuse, it is abuse and we want to correct it, all of us working together. We have been pleased with the cooperation we have had from the American Medical Association in this regard.

I personally put their response into the record and complimented them for it. I expressed my appreciation as an individual and as a member of the committee for the cooperation we have had.

Dr. DORMAN. We appreciate that.

Senator WILLIAMS. I think that is true for our staff, also. But if there are errors, I wish you would be specific and point out, where in our report, we made a mistake.

Dr. THOMAS. We want the record to show we are as interested and probably more so than you in making sure that those men who would engage in fraudulent behavior are treated as criminals. They ought to be prosecuted according to the law.

We would, as professionals, cooperate certainly with any legitimate activity to try to help to get such men expunged from the medical profession who would carry us down that kind of pathway because they would be criminals and we would want to see them treated as such.

But the general point we wish to leave with you is that in a community such as East St. Louis with virtually 80 percent of its people on welfare, it would become obvious that the physicians there will have the bulk of their income from the medicaid program, and we simply wished to say that they are not irresponsible professionals. I am not saying who had anything to do with the release of names. Things do leak, as one of our cabinet officers found a short while ago. So that somebody leaked something that hit the Chicago Tribune in Chicago and caused us a great problem, the men who need to be caught were in fact caught but basically our physicians are doing a good job.

Senator LONG. Let's get this matter straight. So far as this committee is concerned we have done everything anyone could expect of us to protect any doctor from being unfairly smeared.

We can't control the press.

As the chairman of this committee I personally declined to let anybody see any of the names of doctors making more than $25,000 through medicare or medicaid. The $25,000 figure was picked for screening purposes; there was no point initially in taking a look at those making less than that amount, but that we might have some questions to ask about those getting more than $25,000 from these programs.

To protect innocent individuals, we did not release those names. There was one exception. Senator Anderson, who is the chairman of this subcommittee, wanted to release the names and figures with regard to his state of New Mexico and take the responsibility for it. The committee agreed to that and I don't know of anybody in New Mexico who has complained about it.

In your State I understand that the Illinois Public Aid Department, which handles the medicaid program released the figures that you are complaining about. That wasn't this committee releasing them. Your recourse is not to the Federal Government, it is to your State government.

Dr. THOMAS. I shall submit a copy of the news items of the day to clarify in a formal statement from our association the kind of concern that we had for that particular State, for example, so that you will understand the kind of objection we must take to articles saying doctors are rascals or whatever and then to list the names of members of our association.

I might say further I served with the State medical society, in this case. AMA in helping to ferret out the fellows in Illinois who engaged in fraudulent behavior, so it is not a thing of saying we are pulling away from the exercising of our responsibility.

I am happy to know that the committee will make those kind of efforts continually to protect the names and so on of general membership.

Senator LONG. Let me ask you this. Do you know of any doctors, or others connected with the medical profession in Illinois who have been suspended or indicted since this investigation started.

Dr. THOMAS. I don't know of any personal names where I served on a committee where we found that the man justified our dismissal.

Senator LONG. I mean in Illinois.

Dr. THOMAS. I am saying in Illinois now, I am saying I don't know of members. We have several committees throughout the State working with the names of anybody who might be called before a grievance committee, whether that grievance is coming from the Congress, press or from a given patient. I personally have not been engaged in any committee where we have found that.

Senator LONG. Well, let's just understand one another now in regard to this so-called smear business. If you have a justifiable complaint it is with the State of Illinois, not with this Committee so I suggest you take it up with the Governor, not with us. I think your recourse is with either the Governor or with the legislature.

Dr. HILL. May I proceed, sir.

The National Medical Association actively supported the medicare program. Our reason was obvious. Most of the elderly black people of this country simply could not afford adequate medical care. Through our support of the Government program, we hoped to make care available to those who previously could not afford it.

But we supported medicaid reluctantly. It was hastily drawn and hastily passed. We warned at an early date, and have repeated as late as last July to the Secretary of Health, Education, and Welfare that medicaid as currently designed does not really meet the needs of the poor person who is less than 65 years old.

Our primary concern, therefore, has been to improve the quality of care for people who cannot afford to pay for it. And much of the effort, too, has been toward getting black or white physicians to practice among the poor.

Working with the American Medical Association, we have been seeking ways to attract more young men and women from among the poor into medical careers. We hope that as more young blacks and representatives of other ethnic and racial groups from the ghettos go into medicine, they will return to their neighborhoods to practice.

We believe that we can be successful in recruiting physicians into poor neighborhoods. Their numbers will grow with the expansion of neighborhood health centers and other private and public health projects. But the physician—black or white—must be able to make a reasonable living for himself and his family.

He will not practice under the most difficult possible conditions if it means he must also make a financial sacrifice. He must be able to earn an adequate living or he will move his practice elsewhere.

At the present time, his fees come from medicare or medicaid. In the future, we hope to see them come from a health insurance program such as "Medicredit", where the patient owns his own health insurance policy and has a great deal more independence.

But whatever kind of program provides the financial help needed by the poor, the National Medical Association will oppose any effort to restrict the ability of a physician to provide quality care. We shall also oppose any proposal that would result in a limitation or reduction in the number of physicians who are willing to practice medicine in neighborhoods where they so desperately are needed.

In brief, we feel that the burden of providing medical care for the poor falls heavily on the black physician. Criticism of those of us who work in ghetto areas, unwarranted and without fact as it often is, will only deter the delivery of care to these poor people. And, gentlemen, health care programs for them, planned in these committee rooms, will then be doomed to ultimate failure.

We ask the members of this committee and the Congress to join us in a combined effort for a healthier America.

Mr. Chairman, in almost all cases, the physician practicing among the poor is a dedicated and overworked doctor. Just saying so, however, unfortunately does not conjure up in the mind the complete picture of the man we are talking about. To help you visualize the problems facing this physician, we would, with your permission, show a short film which briefly reports on two physicians: one working in the ghetto area of Chicago's west side, the other in a rural county in Kentucky.

Senator Anderson. Go ahead.

(Film shown.)

A Film on Two Physicians

(A visual presentation of two physicians whose practices are hundreds of miles apart but who have one thing in common: the overwhelming percentage of their patients are welfare recipients.

Dr. Risher Watts is director of the Bethany Health Care Center on Chicago's west side. The film follows Dr. Watts as he sees his patients and we hear him discuss "gang visits," and see the problems of practicing in a ghetto area: the huge patient load, the demanding schedule, the lack of physicians, and the need for preventive programs.

From Chicago's west side, the film moves to the hills of eastern Kentucky where Dr. Paul Maddox keeps his Wolfe County Clinic open 24 hours a day, 365 days a year, and sees more than 100 patients each and every day, and sometimes as many as 200. Some of these patients are interviewed and recall what it was like before the doctor came to Wolfe County).

Senator Long. May I just make one comment on that film. I think that the kind of thing we just saw in Kentucky is a disgrace. If this film is supposed to say, this doctor is doing a great job my reaction is that he is not. Based on the figures he gave, these people are getting about 3 minutes attention each, I don't think anybody, I don't care if he is Louis Pasteur, can give anybody much treatment if he is only giving them 3 minutes attention.

It seems to me as though those patients should be getting a lot more attention than they are.

Precisely how we answer that problem, I don't know. But I would just ask one of you how much time you think a doctor should spend on the average with one of those patients? How much time should he take with the average patient.

Dr. Dorman. Senator, that is very hard to decide. It may be just a redressing that he looks at and would ask one of the 12 assistants who are full time with him to put another dressing on.

There are other cases like that heart where you would have to spend at least a half hour or more. The mental cases are perhaps the hardest, where you very often have to spend not only an hour but you have to have them for several times before you find what is at the bottom of it.

This is a case of a doctor who is working in an area that had no doctors. He has been able to bring in one assistant in the meantime. He is building towards better care. It is not a question of is this the best care. We are building with what resources we have to the best care that we can have. We would like to take more time, some cases take a very short time, and some take a lot longer, and we are trying to use the allied health services such as he is using very often to do the things that the physician himself doesn't have to do personally.

He can direct it and give that type of care.

Dr. Roth. Senator, I would like to say, I am sure that no one in this room would be confused with the thought that we represent this as good or even acceptable levels of medical care. But it epitomizes the problem, at least in the areas of the urban slums and in rural areas, the problems that well-intentioned, well-meaning and probably capable physicians have, the frustrations that they have in trying to meet the demands. This stresses, to my mind, one thing and that is the problem

that confronts us, you and our profession, which is to meet the basic issue of today which is an adequacy of manpower and supporting medical manpower and women power to help doctors meet the needs.

You don't meet the problems illustrated here by talking about the imposition of 75th percentiles. You don't meet the problem by trying to talk about the virtues of comprehensive prepaid group practice. You can't make a group out of that doctor. You don't meet the problems, you are not at the basic issue when you are concerned about utilization review.

Senator LONG. But also, may I say, you don't meet the problem by misunderstanding what the other fellow is talking about.

Dr. ROTH. That is right.

Senator LONG. We are willing to pay for the care patients are getting. We are not willing to pay for the care that they are not getting. We don't feel we ought to have to pay for a half hour's attention when the patient only got 3 minutes attention. We are willing to pay well for what he does. I would be willing to pay for that particular doctor more than I receive in the U.S. Senate. But I don't think we have to pay for the care he is not giving those people.

Dr. HILL. Senator, sir, do you realize that doctor indicated he had 12 staff people there working to help him and as Dr. Dorman stated it might be a matter of a person with a severe cut who has come through in that hospital of 150 people he sees and whose treatment can be delegated. However, that doctor is responsible and that doctor has to pay that staff of his if he is going to have well trained personnel.

Senator LONG. I made that point previously. That is why I wouldn't release figures in Louisiana about some doctor getting a large amount of money, when the figures didn't show whether that was what he made or what was split with 12 different people.

We want to provide the kind of care people are entitled to but we don't want to be cheated, we don't want to be overcharged, we want to be treated fairly. We started this program with an estimate of what it was going to cost and those estimates took the services that were then provided and projected the cost to these additional patients.

The estimate was based on costs and payments 20 percent above the going rate on the theory that the pressure on the profession to provide additional services under the traditional laws of supply and demand would cause the price to go up.

It turns out we are paying a hundred percent more than those estimates, and my question is need it be that much?

Dr. DORMAN. Senator, could I answer some of those points.

The American Medical Association does not feel that anyone should be paid except in proportion to the services rendered. So that on these gang visits I may have to see five out of ten people, I should be paid for the five, not for walking past the other five. We agree with you absolutely on that.

In this particular case, I would like to call your attention to the fact that the infant mortality, according to Dr. Maddox, dropped from 80 per thousand to 20 per thousand because he was a doctor serving there. It is an important point that no matter what he did, he at least cut the infant mortality in that particular area. We do not hold for poor care. We want to have the best care for all of our people. But to get some care there is an extremely important point. This is the

point that we wanted to make by showing the problems that we have, how we are fitting the resources that we have to these problems in different areas.

We haven't licked the problem. We need your help on it. But I think we are working at it, and I hope that we can do the job.

Senator LONG. Let's just understand one another. We should not misunderstand, particularly deliberately, what other people have in mind.

Someone told me that Dr. DeBakey received a large amount of money from medicare or medicaid. Not knowing whether it is true or not, my reaction is that anything you paid Dr. DeBakey was not enough, if you look at all he has done for humanity. He probably donated most of that to charity anyway if he got it. But Dr. DeBakey has done a great deal to benefit humanity, and so far as I am concerned he is entitled to every penny he received and even more.

But the kind of people we had in mind were the kind of people that you yourself have undertaken to censure and to proceed against in a professional way; the kind of people who have been indicted by the Federal Government and are being prosecuted for victimizing this Government.

But it is not the people who are going to go to the penitentiary who are costing us the most money. It is people who legitimately can charge more than they were charging in the past for the same service.

Dr. DORMAN. Senator, I would also like to point out that of the increase of 100 percent, only 40 percent is from increased costs. The other 60 percent of that is increased demand of the public, because they know what the profession can give them. So that there has been a large expansion of what the public expects, what the public wants.

Dr. ROTH. Senator, I would also like to point out that like most coins this one has two sides. We have heard a great deal of emphasis, rightly and wrongly, not necessarily stemming from this committee but what the press has picked up and so on, on the question of overcharges.

Now I submit to you that there is across this land particularly in areas where the medicaid program either is nonexistent or grossly inadequate, a great deal of medical care still given by the profession at no charge whatsoever. I would document this in my own case in the State of Pennsylvania where outpatient medicaid services are paid for at a level so low that in my large group we don't even bother to do the paperwork necessary to charge for outpatient medicaid services.

We take care of them just as though the program didn't exist, and give them the best possible care, and we don't submit any charges. I suspect there may be more of this across the land than there are of people who may be making inaccurate charges.

Dr. DORMAN. Mr. Chairman and members of the committee——

Senator ANDERSON. I don't think you have answered Senator Williams' and Senator Long's question. They tried to find out what the support was in your statement, for saying that the staff report "attacked the very physician working closest to the poor."

Will you answer his question.

Dr. HILL. I am sorry, Senator.

Dr. DORMAN. This is Senator Williams' question, sir?

Senator ANDERSON. I thought Senator Williams and Senator Long have both raised some questions.

Senator LONG. I believe the understanding was that you were going to provide for the record the specific places in the staff report where you feel that an irresponsible accusation occurred. We would like to have you point out specifically, what page and what line.

Dr. DORMAN. Dr. Thomas said he would bring that up for you.*

Senator WILLIAMS. That is right.

Dr. DORMAN. I just wanted to make the point that the movie you have just seen was not rehearsed. We asked the staff of the American Medical Association to seek out an example of a physician working in a ghetto area and another of one practicing in a rural poverty area and to tell their story on film. We believe that what you have seen accurately and fairly portrays the work of many of the physicians who serve the poor.

Now, Mr. Chairman, we will all be pleased to answer any other questions which you or the committee have, Mr. Chairman and we thank you for the opportunity of appearing before you.

Senator ANDERSON. Thank you very much.

There will be no further questions.

San Joaquin Foundation for Medical Care and Sacramento Foundation.

Go ahead, Doctor.

STATEMENT OF DR. DONALD C. HARRINGTON, MEDICAL DIRECTOR, SAN JOAQUIN COUNTY FOUNDATION FOR MEDICAL CARE, CHAIRMAN, PEER REVIEW COMMITTEE, UNITED FOUNDATIONS FOR MEDICAL CARE; ACCOMPANIED BY BOYD THOMPSON, EXECUTIVE SECRETARY, SAN JOAQUIN MEDICAL SOCIETY; DR. JAMES C. BRAMHAM, SACRAMENTO COUNTY MEDICAL SOCIETY, PRESIDENT, SCMS CARE FOUNDATION; DR. JOHN M. BABICH, PRESIDENT, SACRAMENTO COUNTY MEDICAL SOCIETY; AND WILLIAM DOCHTERMAN, EXECUTIVE DIRECTOR

Dr. HARRINGTON. I am Dr. Donald Harrington. I am a practicing obstetrician and gynecologist in Stockton, Calif. I am medical director of the San Joaquin Foundation for Medical Care.

With me and making a similar presentation is Dr. James Bramham who is president of the Sacramento County Foundation for Medicale Care. We also have with us Dr. John Babich, who is president of the Sacramento County Medical Society, Mr. William Dochterman, executive director of the society, and Mr. Boyd Thompson, executive secretary of the San Joaquin Medical Society.

I will make an original series of statements, followed by some discussion by Dr. Bramham, and the rest of the staff will be available for questions and answers.

For comprehensive medicaid and medicare coverage the people are dependent upon the programs that you have developed. The people that are dependent have a definite deficit in health. They are the aged, the halt, the blind, and the illegitimate, it is obviously going to be costly to bring these people up to normal health patterns and it will take a comprehensive program to do this.

*At presstime, August 10, 1970, the material referred to had not been received by the committee.

In the main, the programs in this country are rather primitive. In the programs of insurance, the medical care coverage does not cover the care of people in the outpatient and home areas properly and for diagnostic services.

The San Joaquin County Foundation for Medical Care has been administering medicaid on a prepayment program for 1½ years and has been administering the Medi-Cal program for 10 months.

The University of California at Los Angeles School of Public Health in their study of our Medi-Cal program said that due to the willingness of providers to see these patients (medicare and medicaid) people, 10 percent more of sick were given care than in the "control" counties.

Also due to quality review here the cost per patient was 12 percent less and the cost per eligible was 24 percent less.

A similar study done by the National Pharmaceutical Council shows a similar saving per recipient and 75 cents per eligible members for acute hospitalization showing our administrative programs help expand the care at a cheaper cost to the Government.

The Sacramento Foundation has a very interesting experiment going on in hospital control and they will speak on this subject.

In spite of these savings our AFDC recipients numbering 30,000 individuals, AFDC, Aid to Families with Dependent Children, (these are both adults and children) in spite of these savings, our people, our children, made 9,314 pediatrician visits in 1968 and 4,172 pediatrician visits in the first 4 months of 1969.

Also these children received in 1968, 2,774 immunizations and in the first 4 months of 1969 they received 3,395 immunizations.

Our point in this is, comprehensive care is needed, is possible, and, we think with the proper administrative controls is cheaper than the kind of medical care that we are seeing throughout.

Payment for physicians. There has been a great deal of discussion about the payment of physicians concerning the use of the usual customary and reasonable fee versus a fee schedule. Our program is paying medicaid on a usual customary and reasonable fee. It is not paying, as the State of California medicaid program is at a 60 percentile. It is because we have been able to pay the usual customary and reasonable fee that our people are able to go into the pediatrician's and internist's offices and receive true quality care which we feel is cheaper than the rush into the episodic care which this doctor was forced to give as you saw in the A.M.A. film. These two things, quality medical care with comprehensive coverage, and usual, customary, and reasonable fees cannot exist in a vacuum, it is absolutely necessary that peer review be utilized.

Peer review is a popular term at the present time. I would like to point out that the San Joaquin County Foundation for Medical Care has been using peer review as an on-going payment basis over the last 16 years. At the present time it covers approximately two-thirds of the people in our county.

How do we do peer review. The claims for all people—medicare, medicaid, our insurance programs which are over and above our medicare and medicaid programs—come to our foundation for medical care where they are reviewed for completeness. They then are subjected to careful scrutiny by claims girls who are trained in the art of discovering those kinds of claims that we want to see.

Now, this point is extremely important. Too much peer review depends upon nonmedical minds deciding what are questionable claims. You have to have somebody trained in the field to bring out those things that are questionable, and then those things can be studied. Too often some insurance person says "this is a questionable claim" and refers it to the claims review committee.

I would like, if the committee would please, turn to certain pages—have you all got this book, Progress in Pre-payment? [1]

I will briefly refer to this and at a later date you and your staff can go over it in greater detail. I would like to point out several things rather rapidly. On pages 6 and 7 and 9 you will find what we call our "model treatment systems". These have been decided by the physicians in our area in cooperation with a committee of the California Medical Association, and these are in general the kinds of things that our claims people look for. If they do not meet these criteria of care these claims then are sent to our physicians for more careful review.

Our experience and the experience of foundations in other parts of California, show that 85 percent of the claims in a comprehensive program go through without review by a peer. They are proper and they are paid.

Of our claims 15 percent go to physician review, and 2 percent have to go to committee review. The next few pages we will skip over, these are the kinds of letters that we write to our physicians to correct or to get information and you will see there are all kinds of errors that we are talking about. Errors of omission, there are errors of commission, errors of overutilization but I would like you to turn to pages 22, 23, 24, 25, 26, and 27, but just 22 and 23 to start with. This is the fundamental document that is required in a peer review system of professional services. This is a patient profile.

The reason——

Senator Long. What page is that?

Dr. Harrington. Page 22. The reason we are using this particular patient is when we got started in our medicaid program we did not have EDP—electronic data processing—capability so that there are errors of overutilization we were unable to pick up at the beginning of the program. Page 22 is a patient profile and it covers a fairly long period of time. If you will look across from left to right you will see every item is entered by date of service.

Our claims girls receive these documents on microfilm and they are updated every 2 weeks. The claims are reviewed against the patient's past history. We are, as far as I know, the only place in the country where all claims for medicaid and medicare patients are collected in one adminstrative entity, giving us the ability to review hospital problems, drug problems, etc. If you will go to the bottom of this patient's profile we will see a tremendous number of drugs that this person was using.

This has been corrected. This patient, if you will scan it here, saw four doctors in 1 day, received four prescriptions and went to four pharmacies. We worked with our welfare department. She is now on prior authorization and has one physician who is dedicated to take care of her and she must receive permission to go to another physician. Patient over-utilization is a problem, not as great as some people would believe but it is a problem.

[1] The book referred to appears as app. B of this hearing.

If you would turn to page 28, it sounds like we are in a Methodist hymnal——

Senator ANDERSON. It sounds like good work too.

Dr. HARRINGTON. This is a sad song. This is a group of two physicians in our area——

Senator LONG. Let me just ask you something, you referred to this patient and said that it was an extreme case. How much money was spent on that patient?

Dr. HARRINGTON. I can't tell you but if one of your people can add up those numbers it is considerable.

Senator LONG. It is a lot of money.

Dr. HARRINGTON. That is correct. I won't go into the EDP problems here because it is a fiscal thing but there are so many things here that it is not the time to consider it, but I would like to give you an overview.

Page 28, this is a provider profile. Providers in our terminology are physicians, podiatrists, chiropractors in medicaid not in medicare, hospitals, nursing homes, extended care and long-term care, hearing aid dealers, medicare transporters, ambulances, anybody who impacts a patient is a provider, and each one of these providers has—in our shop—a complete profile so we know exactly what is going on.

This is the provider profile of two physicians, who are practicing in a ghetto area, and we have a lot of them who are there who are doing good work, these two are not. These two physicians (if you will notice tonsillectomy was circled 139), they did almost one-half of the tonsillectomies in this group, they did more tonsillectomies than all the ear, nose, and throat men in the community put together, and they are now on prior consultation, and they cannot do it without a prior consultation with the pediatrician or an ear, nose or throat man in the program.

Senator LONG. Let me get this straight. They did all these tonsillectomies and you challenged that item?

Dr. HARRINGTON. Correct.

Senator LONG. And they want $12,385?

Dr. HARRINGTON. The problem is this, the patient profile is good for office visits overutilization of shots and overutilization of office work.

However, tonsils come only one to a customer, so reviewing the patient's profile does not help us a bit. We do have to do retrospective review and study to provide it. In other words, we have to see what treatment patterns the provider has.

Senator LONG. Does this suggest that this fellow was taking everybody's tonsils out?

Dr. HARRINGTON. Yes, sir.

Senator LONG. In other words, everyone he got in the office was told "your tonsils ought to come out."

Dr. HARRINGTON. Yes, sir.

Senator LONG. You take some aspirin tablets and that will relieve your headache, but meanwhile we ought to take your tonsils out.

Dr. HARRINGTON. Exactly right, and if you will see your point is well shown. This group is also a shot expert group. They did, you can see it listed here, in fact despite the fact that we corrected them, they billed us $41,000 for follow-up office visits and we knocked them $3,258 that we refused to pay and if you see that circled line about half way down,

the second page you will see 7,006, that is the number of office visits which these gentlemen did. They billed us $42,000, and we refused to pay $3,200 of which 133 were overutilization, 369 we refused to pay at all, and 88 went to committee for further study. So they are a high utilization group in office practice.

We are the only fiscal intermediary that I know of that lists injections by type of injections. Everybody else lumps them into one number. We have on all of our patients the injections they got and we find some of our physicians, are not aware of the fact there is oral penicillin, oral estrogens, oral iron, oral vitamins. They don't know this.

So they give injections to do this. Well we bring them into the committee and we educate them, and tell them there are and we correct the matter.

This group of doctors did one injection for every 1.8 office visits which is way over our community norm and if you will notice, with all of their expertise with the needle they only did 26 immunization—lousy medical care.

Now, the reason that I can sit here and give you this information is because these are a small percentage of our practitioners, and I believe with AMA these people must be disciplined but we have to have the tools. We must know what we are doing.

Senator Long. Let me get this straight again. You are saying that in case after case where these doctors could have just given a person a prescription or handed him some pills they were giving him a shot instead.

Dr. Harrington. Yes, sir; we do have a problem, however. In our general physicians, our good ones, they have made us realize that many of these patients—and we are dealing with Mexican-Americans and with Negroes—particularly the Mexican-Americans because of their ethnic backgrounds do not necessarily, are not necessarily willing to take pills. Therefore, the physicians feel that they need to give an injection of penicillin with an office visit for a child with a cold or sore throat or what not. We will allow that injection of penicillin with that one office visit even though in our hearts we don't really think this is needed but we understand their thinking and their problem.

However, if their rapport with those patients is good enough to get them back in for repeated shots we think their rapport is good enough for them to instruct them how to do it orally so we will not give them repeated shots. These are the kinds of problems you get into.

I would like to now turn to page 31. 31 is a ghetto doctor who did give a lot of shots. He is a good doctor, though he was misguided. He didn't understand he was dealing with episodic medicine, the kind of treatment you saw in the AMA picture where these people flocked to his waiting room, there was nobody else there. This was also true in the early days of our medicaid program.

He had to take care of them, the quickest way was to give them a shot and get them out. We brought him in, discussed the problems with him and he then cut down. If you will notice he is now down to one injection for every 5.7 office visits and if you will also notice this doctor does practically no tonsillectomies although he does do them so he is a good physician.

Now turn to page 34, 35, and 36, and this is this same doctor's prescribing pattern.

If you will notice in the year of study here, he prescribed—the summary of this doctor's prescribing habits is on page 42—$45,398 worth of drugs in the year under study. In the same period of time he received for his own professional services $32,000, and his practice is practically all ghetto. He is not getting rich on his practice because his overhead probably costs him around $17,000 or $18,000. So immediately, red flags went up. We thought he stopped his shots but he is now giving too many prescriptions, plus the fact we found all of his——

Senator LONG. On this subject, I notice that the drug you list has a drug code and name. Are these generic names or trade names?

Dr. HARRINGTON. These are the generic names, sir.

Senator LONG. You don't bother to try to call the same drug by 50 different names then?

Dr. HARRINGTON. No, the pharmacists have to put down the generic name. As a matter of fact, we are working on a formulary that the State of California has, a good formulary, and so we are working on this.

But to show you what a formulary will do, if you turn to page 35 it will show you that 503 cases he ordered 32,485 tablets of codeine aspirin and phenacetin and caffein. We questioned this, and we questioned the fact that 90 percent of his prescriptions went to one drug store that was close by. At the time of the printing of this book that is all the information we had. We studied this subsequently and we have gone through all of our providers profiles and the prescribing habits and we found these things.

Generally, in general, these are family doctors, they are taking care of people with diabetes, heart disease, colds and this sort of thing. Generally they will prescribe, and we did document this by our statistics, they will prescribe one and a quarter to one and one half times of the cost of their services. Pediatricians a little less than this, internists 1 to 1, in other words if he is doing $10,000 worth of professional work he will prescribe 10,000. Surgeons, myself as a gynecologist, practically none.

So the point I am getting at here is a doctor practicing good medicine and yet on a statistical study taken without analysis could have been hung for being a bad prescriber. We know the other two fellows are bad and their prescription habits are practically nil. They would rather do it by shots.

We won't go through the rest of these but I would like to now turn to the bible, the blue book, to page 137 and you have done exactly the same thing we have done and if you will take physician A, and I want to get back to this matter of usual, customary, and reasonable, I want to get back to fee schedules and I want to get back to costs, we can prove from studies in Kern County, Fresno County and San Joaquin County (where we have equal statistics) that to review for fee overcharges will salvage 1½ percent. It will cost you more administratively to pick up overcharging than what you make out of it.

We have got to do it, don't misunderstand me, and we do it as a byproduct of our other review. Review for overutilization the kind of stuff I have been talking about, the kind of stuff Sacramento is doing, we have at the present time 39 foundations in California, in 32 counties, with 8,000 doctors under contract to subject themselves to this kind of review program.

In State of California also Hawaii has it, Denver has one, they recently voted in a statewide; Georgia is looking into it, there is movement all over the country among physicians to move into the foundation program.

Let's go to page 137, when you get up here you see that the guy charged $84,578.50. Naturally everybody says he is an overcharger. He is an overutilizer. If you will look at the office visits he did, he had 286 patients and he did, an average of 45 visits per patient for a charge of $4.90. He is cheap, but he is probably a crook.

Let's get down to injections. He is worse than any of our guys. He gives not one injection for every one and one-half office visits, he is giving one and one-half injections for every office visit, in other words he is doing it extra.

The same thing is true for practitioner B and so forth. I think the point made earlier, the $25,000 is a good fishing area but where you really do it is when you get into this area here. This is where the meat of what you are going to do and what you said earlier, Senator, I think is quite true. It is fine to have the people that you prosecute for fraud taken care of but that is not where our problem is. Our problem is just what we were talking about.

Now, I would like to go on quickly to administration, I am taking too much time.

You people here in Washington could not have better developed an administrative program that could be more easily robbed if you had put your mind to doing it, than the on you have got. Let me illustrate using myself as a gynecologist, seeing a woman, seeing a woman in the outpatient department of St. Joseph's Hospital. The way the administration is set up is as follows. My bill, professional bill, would go to Blue Shield. The outpatient department's bill would go to Blue Cross. If an X-ray were ordered the professional part of the X-ray would go to Blue Shield and the technical part would go to Blue Cross. If I ordered a drug it would go to Blue Cross but because of the volume it would go to a different department, and in the State of Colorado this would have gone to the welfare department.

There is absolutely no administrative correlation of services. I am sure I could bill for surgery not performed and get paid for it because there is no way that the administrator of the case for my service knows she was in the hospital.

So again I think that the way that you people have set up the administration of medicare and medicaid was designed to be cheated against, and there are enough of us in our profession, and there are enough druggists and there are enough optometrists, and I think if preachers were involved there would be enough preachers, that would cheat against this program the way it was set up.

Senator Long. In other words, knowing they could get away with it a lot of them would cheat?

Dr. Harrington. Another thing, you folks caused us a great deal of problem and I am talking now about administration as it comes down from these Halls. Let us take an acute facility, an extended care facility, a long-term care facility, and a domiciliary care facility. If you want a messed up administration this is it. I hospitalize a person in an acute facility for medicare. Medicare pays it. If it is medicaid, medicaid pays it, that is all right.

If I put her in an ECF facility under medicare, medicare pays it, medicaid won't pay ECF for a medicaid patient. She goes into a long-term care facility. If I move her from ECF to long-term care, medicaid pays it.

Now, if I move her from the long-term facility down to board and room, the board of supervisors pays it. So here we have four different tax bases forcing the practicing physician to move these patients from one place to another, and what is even worse, you will go to a nursing home or extended care facility in a four-bed ward and see two long-term care patients and two extended care patients in the same room geting the same kind of care, and if this makes sense to you I will buy in with it.

So, I have a few recommendations. I hope I am not impertinent. First, I feel that steps should be taken to make the administration of this program limited by geography, not limited by provider boundaries.

In other words, if an organization is going to administer the program, it should administer it totally, medicare, medicaid, and it should cover all providers, drugs, physicians, the whole group. If they are not big enough to cover more than San Joaquin County that is all they should cover, if they can cover half of California, beautiful: but their limitations should be geographic, not by provider group so it is all collated in one area and you can get at the kind of administrative continuity we are talking about.

Second, I feel strongly that every medical society in the area should be required to install on-going—before payment—peer review and not retrospective, as the horse is out of the pasture, and trying to get the money back is difficult and the medical care involved is terrible, therefore on-going before payment peer review is essential.

Thirdly, I feel that somehow we should pull funds out of the various tax bases into a single pool to be paid for ECF, domiciliary care, and long term so that best treatment can be developed for these patients without worrying who is paying the ticket.

And the last thing I would like to recommend to your staff is that ECF facilities be pure ECF facilities, they should not include long-term care facilities, and that they be related to an acute hospital.

Dr. Wheeler in California has made a study of this and has shown the utilization of ECF facilities related to acute hospitals is by far superior to those that are distributed 10 or 12 miles away. No X-ray, no laboratory, difficult for on-going care.

I have not mentioned too much about hospitals because of the extremely interesting and important innovation which has been brought to us by Sacramento Foundation for Medical Care, so if we could, I would like to have them talk to this now, please.

(Dr. Harrington's prepared statement follows:)

STATEMENT BY DONALD C. HARRINGTON, M.D.

I am Donald C. Harrington, M.D., medical director of the San Joaquin County Foundation for Medical Care and chairman of the Peer Review Committee of the United Foundations for Medical Care, and am in private practice in Stockton, California.

The San Joaquin County Foundation for Medical Care is a corporation that is owned and operated by the San Joaquin County Medical Society. It acts as the administrative and fiscal arm in the development and administration of medical care programs for approximately two-thirds of the population of San Joaquin

County. For sixteen years we have, with the cooperation of the insurance industry, been involved in medical care plans covering the major groups in our area. Over the past two years through a contract with the State of California the Foundation has "gone on risk" for the medical care services for those recipients of Medicaid in San Joaquin County. There are 26,000 people involved in this risk pool and this program has been carried on successfully for the past two years. The San Joaquin Foundation is only one of the many foundations that comprise the United Foundations for Medical Care. Foundations are in existence and administering medical care programs in Hawaii, Colorado, and 36 counties in California. They are being implemented in several other states at the present time. Eight thousand physicians are on contract with the various Foundations to render care to the people covered under these Foundation programs. Our experience with the Medicaid and Medicare programs over the past several years has made us come to three major conclusions. A discussion of these topics is the purpose of my presentation to your committee.

1. Medicare and Medicaid, following on the experience of the Federal Employees contracts, are implementing a broadly stated desire of the American public. That desire is for comprehensive medical care coverage paid for out of some type of trust fund. The Medicaid program for the first time has brought the aged, the halt, the blind, and the illegitimate into a pattern of comprehensive health care. Inasmuch as these people all have a marked deficit in past health care with a resulting increase of untreated and frequently undiagnosed medical conditions, these programs have been costly. The main problem in administering a comprehensive medical care program is the fact that for the most part the fiscal intermediaries involved had experience only with basic non-comprehensive coverage and were unable to determine and to correct aberrations in medical care that resulted in great overutilization in the area of office visits, laboratory, and injections. Coupled with this inexperience, the government chose diverse fiscal intermediaries to cover large geographic areas, each fiscal intermediary becoming responsible for a different portion of health care services administration. To illustrate, in most states a gynecologist seeing a woman in the out-patient department of a hospital would have the billings for the out-patient department go to one fiscal intermediary (usually Blue Cross), his services go to another fiscal intermediary (usually Blue Shield); if an x-ray were ordered the technical part of the x-ray would go to a separate fiscal intermediary (usually Blue Cross), and the professional portion of the x-ray would go to a different fiscal intermediary (usually Blue Shield). If drugs were ordered, an entirely different administrative entity would handle the administration of the drug program. This method of unrelated administration makes it extremely difficult to uncover areas of overutilization, even with the most comprehensive retrospective review techniques.

2. Our second conclusion is that the usual, customary and reasonable method of charging, properly administered, produces broader coverage at lower cost than a strict fee schedule. The San Joaquin prepaid program for the recipients of Medicaid has utilized the usual, customary and reasonable program for 2½ years. Our program has been under intense scrutiny by the University of California at Los Angeles School of Public Health. This study, although not completed, has shown that in San Joaquin County, ten percent more of the welfare recipients received medical care at a lower cost per patient and a lower cost per recipient than in the test counties. It also showed that a higher number of physicians in the county were involved in the care of these people rather than restricting them to the physicians in the ghetto areas. This has been gratifying to the Foundation because we are seeing a large number of these people having their children go to pediatricians for care and to internists for some of the more complicated major illnesses. The U.C.L.A. study also showed that although the costs for office visits were higher in San Joaquin County, they were markedly lower for hospital costs, thus illustrating that a free profession can do much of the necessary work in the out-patient or office area and restrict expensive hospitalizations to those in need of it. The crux of this matter, of course, is careful control of usual, customary and reasonable and the most important word of the three is, of course, "reasonable". In California we have differences in fee practices from a mountain county to the Beverly Hills section of Los Angeles and, as a matter of fact, from Beverly Hills to the Watts District of Los Angeles. These variations in fee practices are illustrative of the charges that will occur from state to state in our nation. These variations in fee practices make implementing a fee schedule extremely difficult and so, again, our conclusion that

usual, customary and reasonable, properly administered, is a better tool than a fixed fee schedule.

3. With our conclusions that comprehensive medical care is a desire of our population and, indeed, a need, and in view of our conclusion that usual, customary and reasonable, properly administered, are both necessary to carry on the Medicare-Medicaid program, our third conclusion is perhaps the most important. Peer review on an on-going basis is a necessity to control any medical care program. At the present time because of the massive number of people and the comprehensiveness of the program and the lack of experience in on-going review, the fiscal intermediaries handling these programs have perforce limited themselves to retrospective review, finding problems long after the patient has been improperly treated and the provider improperly paid. Also, because of the massiveness of the problem and the ease with which dollars can be programmed into electronic equipment, the fiscal intermediaries have concentrated on fee review. It has been our experience and that of the other Foundations that are doing on-going review that corrections in fee will net approximately 1½% of the dollars spent in a medical care program; whereas review for over-utilization will uncover enough aberrations to produce a savings of approximately 12½%. The Foundations for Medical Care have been doing "on-going" review from the beginning of their involvement in medical care. The primary document needed for on-going review is the patient's profile (illustration attached). As you will see from studying the patient's profile, the listings are by date of service, the provider's license number, followed by a code number that describes either the diagnosis or the procedure done or the drug prescribed. It also tells the number of dollars billed, the dollars paid or not paid, and whether the claim was subjected to review. Our claims people receive these patient profiles on microfilm reels on a bi-monthly basis. Every claim that comes through the Foundation office is reviewed in the light of the patient's past experience.

If unusual practices are uncovered this is then subjected to peer review either by individuals or committee. For this peer review we also have provider profiles for all providers working under the Medicaid and Medicare programs. At the present time the type of review done by Foundations is manual review with data processing back-up. It is impossible to implement this type of review in a large community such as Los Angeles, New York or Washington. It is for this reason that the San Joaquin Foundation has involved itself along with the United Foundations in attempting to develop the necessary information to carry on an on-going review program using electronic data processing for most of the review procedures. Our past experience shows that 85% of all claims clear the manual review mechanism and go on for immediate payment. Fifteen percent are sent to peer review, of which two percent reach the committee level. These latter figures are easily capable of manual review and it is our intention to develop electronic data processing to the point were the 85% can be cleared by the machine without having to be handled in a manual fashion. At the persent time the State of California has entered into a contract with four insurance companies who are in turn subcontrating with the United Foundations to develop such an on-going electronic peer review method. H.E.W. and several of its departments is also interested in this program and separate efforts are being carried on by the San Joaquin County Foundation in this direction.

As a result of these conclusions, we have a few recommendations:

1. That in each geographical area the administration of both Medicare and Medicaid be under the control and responsibility of one fiscal intermediary so that all claims are processed in one location. The limitation as to size of the administrative organism carrying on this work should be geographical and cut across geographical boundaries rather than disturbing existing medical care relationships.

2. Peer review on an on-going basis should be a requirement of all administrative agencies working under the program. If they are incapable of carrying this on at the present time, certainly a timetable should be developed during which they would proceed to develop the necessary competence in on-going peer review.

3. In those areas showing experience and responsibility in the area of peer review, the fees paid to all providers should be those of the marketplace, utilizing the principles of usual, customary and reasonable with the foregoing requirement of adequate administrative control to assure that the pressures of the marketplace are reflected in the payments made by the third party in the Medicare-Medicaid programs.

Dec. 10, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							0060522
Do	0A08691	20 MD–1–03170	Brain synd oth unspec							0060522
Do	0A08691	20 MD–1–03340	OTH ill defined lesion CVA							0060522
Do	0A08691	20 MD–1–04470	Benign hypertension							0060522
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	10.00	10.00	R	0060522
Nov. 18, 1969	0A08691	20 MD–2–09019	do	1		NH	10.00	10.00	R	3390617
Nov. 15, 1969	0A08691	20 MD–2–09019	do	1		NH	10.00		3	3390617
Nov. 14, 1969	0A08691	20 MD–2–09019	do	1		NH	10.00		3	3390617
Nov. 4, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							3390617
Do	0A08691	20 MD–1–03179	Chr brain synd oth unspec							3390617
Do	0A08691	20 MD–1–03340	Oth ill defined lesion CVA							3390617
Do	0A08691	20 MD–1–04470	Benign hypertension							3390617
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	10.00	10.00	R	3390617
Oct. 28, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50	7.50	R	3090725
Oct. 21, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50		1	3090725
Oct. 15, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							3090725
Do	0A08691	20 MD–1–03179	Chr brain synd oth unspec							3090725
Do	0A08691	20 MD–1–04470	Benign hypertension							3090725
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	7.50	7.50	R	3090725
Sept. 16, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50	7.50		2790721
Sept. 9, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50	7.50		2790721
Sept. 4, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							2790721
Do	0A08691	20 MD–1–03179	Chr brain synd oth unspec							2790721
Do	0A00691	20 MD–1–04470	Benign hypertension							2790721
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	7.50	7.50		2790721
Aug. 5, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							2550347
Do	0A08691	20 MD–1–03179	Chr brain synd oth unspec							2550347
Do	0A08691	20 MD–1–04470	Benign hypertension							2550347
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	7.50	7.50		2550347
July 29, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50	7.50	R	2170447
July 22, 1969	0A08691	20 MD–2–09019	do	1		NH	7.50	7.50	R	2170447
July 18, 1969	0A08691	20 MD–1–02600	Diabetes mellitus							2170447
Do	0A08691	20 MD–1–04470	Benign hypertension							2170447
Do	0A08691	20 MD–2–09019	Nursing home and conv hospital	1		NH	20.00	20.00	R	2170447
July 2, 1969	Y42022	20 MD–2–07357	G.I. series	1		IPH	21.00	21.00	50 G	2670168
June 25, 1969	Y42022	20 MD–2–07360	X-ray colon	1		IPH	18.00	18.00	60 G	2130545
June 21, 1969	Y42022	20 MD–2–07101	X-ray chest	1		IPH	6.00	6.00	33 G	2130545
May 28, 1969	Y42022	20 MD–2–07101	do	1		OPH	6.00	6.00	33 G	1902516
May 13, 1969	0G5879	20 MD–2–09004	Office visit	1		OFF	7.50	6.00		1292178
May 7, 1969	0G5879	20 MD–1–03859	Cataract unspecified							1292178
Do	0G5879	20 MD–1–03870	Glaucoma							1292178
Do	0G5879	20 MD–1–0388i	Aphakia							1292178
Do	0G5879	20 MD–2–09004	Office visit	1		OFF	7.50	6.00		1292178
Apr. 7, 1969	Y42022	20 MD–2–07101	X-ray chest	1		OPH	6.00	6.00		1690455
Mar. 11, 1969	0C24276	20 MD–1–06980	Other inf skin and subtissue							151168
Do	0C24276	20 MD–2–09004	Office visit	1		OFF	7.00	7.00		1511688
Do	0G5879	20 MD–1–03859	Cataract unspecified							1280274
Do	0G5879	20 MD–1–03888	Aphakia							1280274
Do	0G5879	20 MD–2–09004	Office visit	1		OFF	7.50	6.00		1280274

Jan. 28, 1969	OC24276	20 MD-1-06980	Other inf skin and subtissue								0912582
Do	OC24276	20 MD-2-09004	Office visit	1		OFF	7.00	7.00			0912582
Dec. 27, 1968	OG4333	20 MD-1-02600	Diabetes mellitus								0841865
Do	OG4333	20 MD-1-02870	Obesity								0841865
Do	OG4333	20 MD-2-09005	Followup off. visit	1		OFF	7.50	7.50			0841865
Dec. 26, 1968	YZ0637	20 MD-2-08722	Glucose	1	0G4333	OFF	5.00	5.00			0842066
Dec. 20, 1968	OC24276	20 MD-1-07101	Keratoderma								0760532
Do	OC24276	20 MD-2-09004	Office visit	1		OFF	7.00	7.00			0760532
Dec. 12, 1968	OG5879	20 MD-1-03859	Cataract unspecified								0761234
Do	OG5879	20 MD-1-03888	Aphakia								0 234
Do	OG5879	20 MD-1-05478	Visual fields complete	1		OFF	12.00	12.00			0761234
Jan. 26, 1968	OS4333	20 MD-2-09005	Follow-up off. visit	1		OFF	7.50	7.50			0551219
Jan. 21, 1968	OS4333	20 MD-1-02600	Diabetes mellitus								0551219
Do	OS4333	20 MD-2-09005	Follow-up off. visit	1		OFF	7.50	7.50			0551219
Jan. 20, 1968	OC24276	20 MD-2-09004	Office visit	1		OFF	7.00	7.00			0480173
Jan. 7, 1968	OC24276	20 MD-1-05980	Other infskin and subtissue								0480173
Do	OC24276	20 MD-2-09004	Office visit	1		OFF	7.00	7.00			0480173
Jan. 1, 1968	OG4333	20 MD-1-02600	Diabetes mellitus								0130686
Do	OG4333	20 MD-2-09005	Follow-up off. visit	1		OFF	7.50	7.50			0130686
Feb. 10, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00		4	3584045
Feb. 8, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00		4	3584045
Feb. 4, 1969	ORP1857	34 MD-4-90447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00		4	3584045
Feb. 2, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00		4	3584045
Feb. 28, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00		4	3584045
Feb. 17, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00		4	3584045
Do	ORP1857	34 MD-4-09465	Home visit	1			6.00	6.00	4		3584045
Feb. 13, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1			3.00	3.00	4		3584045
Do	ORP1857	34 MD-4-09465	Home visit	1		NH	6.00	6.00	4		3584045
Feb. 10, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	1		NH	6.00	6.00	4		3584045
Do	ORP1857	34 MD-4-09465	Hone visit	1			3.00	3.00	4		3584045
Feb. 4, 1969	ORP1857	34 MD-4-09447	Trmt comb procedures 30 M	6		NH	54.00	54.00			2724075
Feb. 21, 1969	Z30529	40 MD-4-D9558	H tank extra large	1		NH	12.50	12.50			0134072
Feb. 11, 1969	Z30529	40 MD-4-09988	Misc materials	1			15.75			5	1913147
Do	Z30529	40 MD-4-09988	do	1			135.00			5	1913147
Do	Z30529	40 MD-4-09988	do	1			152.25			5	1913146
Do	Z30529	40 MD-4-09988	do	1		H	6.50	6.50			2124006
Do	Z30529	40 MD-4-09988	do	1		H	16.80	16.80			2124006
Feb. 14, 1969	Z30106	43 MD-4-03555	Lab home call day	1	0A08691	OFF	5.00	5.00			3644059
Do	Z30106	43 MD-4-08722	Sugar	1	0A08691	OFF	7.00	5.00	2		3644059
Feb. 16, 1969	Z30106	43 MD-4-08555	Lab home call day	1	0A06891	NH	5.00	5.00			2624007
Do	Z30106	43 MD-4-08722	Sugar	1	0A06891	OFF	7.00	5.00			2624007
Feb. 7, 1969	Z30106	43 MD-4-08555	Lab home call day	1	0A08691	NH	5.00	5.00			2744002
Do	Z30106	43 MD-4-08722	Sugar	1	0A08691	NH	7.00	5.00	2		2744002
Do	Z30106	43 MD-4-08745	Urea nitrogen	1	0A08691	NH	7.00	5.00	2		2744002

Feb. 30, 1969	Z30106	43	MD-4-08555	Miscellaneous			1	0A08691		5.00	5.00		2180372
Do	Z30106	43	MD-4-08722	Sugar			1	0A08691	OFF	7.00	5.00		2180372
Feb. 21, 1969	Z30106	43	MD-4-08555	Miscellaneous			1	0A08691	NH	5.00	5.00		2180371
Do	Z30106	43	MD-4-08628	Blood complete count			1	0A08691	OFF	7.00	6.00		2180371
Do	Z30106	43	MD-4-08681	Hematocrit			1	0A08691	OFF	2.40	2.00		2180371
Do	Z30106	43	MD-4-08722	Sugar			1	0A08691	OFF	6.00	5.00		2180371
Do	Z30106	43	MD-4-08936	Urine complete routine			1	0A08691	OFF	3.00	2.50		2180371
Feb. 26, 1969	056	50	HS-2-B0021	2-3-4 bed room			1		OPH	16.50	16.50		1741016
Feb. 27, 1969	056	50	HS-2-B0021	do			1		OPH	16.50	16.50		1741130
Feb. 11, 1969	056	50	HS-2-B0021	do			1		OPH	16.50	16.50		1741130
Feb. 15, 1968	056	50	HS-2-B0021	do			1		OPH	16.50	16.50		1740920
Feb. 29, 1969	056	52	HS-2-B0021	do			1		OPH	38.00	38.00		1741907
Feb. 26, 1969	056	52	HS-2-B0021	do			1		OPH	16.50	16.50		1741907
Feb. 19, 1969	056	52	HS-2-B0021	do			1		OPH	38.00	38.00		1741907
Feb. 6, 1970	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	0197958
Feb. 30, 1969	0A10714	26	RX-3-2644E	Reserpine tab	0.25 MG	25	100	0A08691		2.90	2.90		0096644
Do	0A10714	26	RX-3-3001E	Digitoxin tablet	0.1 MG	30	30	0A08691		2.60	2.60		0096643
Do	0A10714	26	RX-3-63508	Chlorpropamide tablet	250 MG	30	30	0A08691		5.00	5.00		0096645
Feb. 29, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	0096642
Feb. 24, 1969	0A10714	26	RX-3-9811B	do	Equip**	UTD	1	0A08691		1.65	1.65	77	0096642
Feb. 16, 1969	0A10714	26	RX-3-9811B	do	Equip**	UTD	1	0A08691		1.65	1.65	77	0096640
Do	0A10714	26	RX-3-9811A	Urine bags		UTD	1	0A08691		2.85	2.85	77	0096640
Dec. 15, 1969	0A10714	26	RX-3-9816A	Feeding tube		UTD	1	0A08691		1.90	1.90	77	0096637
Do	0A10714	26	RX-3-9830A	Urine bags		UTD	1	0A08691		6.50	6.50	77	0096639
Dec. 9, 1969	0A10714	26	RX-3-3307B	Methyldopa tab	250 MG	33	100	0A68691		9.45	9.45		3576032
Do	0A10714	26	RX-3-3551A	Spironolactone/hydrochlo		30	60	0A08691		8.40	8.40		3576030
Dec. 2, 1969	0A10714	26	RX-3-2644E	Reserpine tab	0.25 MG	25	100	0A08691		2.90	2.90		3576081
Dec. 1, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	3576033
Nov. 24, 1969	0A10714	26	RX-3-6350B	Chlorpropamide tablet	25 OMG	30	30	0A08691		5.00	5.00		3395018
Nov. 18, 1969	0A10714	26	RX-3-9800D	Oxygen mask	(**)	UTD	1	0A03691		1.80	1.80	77	3576204
Nov. 16, 1969	0A7243	26	RX-3-3001E	Digitoxin tablet	0.1 MG	50	50	0A08691		2.25	2.25		3369806
Nov. 11, 1969	0A10714	26	RX-3-2156J	Phenobarbital tab	¼ GR	25	100	0A08691		2.42	2.42		3395022
Nov. 6, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	3395020
Do	0A10714	26	RX-3-9830A	Urine bags		UTD	1	0A08691		6.50	6.50	77	3395019
Nov. 4, 1969	0A10714	26	RX-3-3551A	Spironolactone/hydrochlo		30	60	0A08691		8.40	8.40		3395021
Oct. 30, 1969	0A7243	26	RX-3-3307B	Methyldopa tab	250 MG	33	100	0A08691		8.30	8.30		3076230
Oct. 28, 1969	0A10714	26	RX-3-2644E	Reserpine tab	0.25 MG	25	100	0A08691		2.90	2.90		3095331
Oct. 22, 1969	0A10714	26	RX-3-9811A	Catheters		UTD	1	0A08691		7.85	7.85	77	3095334
Do	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	3095335
Oct. 21, 1969	0A7243	26	RX-3-2156J	Phenobarbital tab	¼ GR	25	100	0A08691		1.75	1.75		3076229
Oct. 15, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	3095332
Oct. 14, 1969	0A10714	26	RX-3-3551A	Spironolactone/hydrochlo		30	60	0A08691		8.40	8.40		3095330
Oct. 8, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A03691		1.65	1.65	77	3095333
Oct. 1, 1969	0A10714	26	RX-3-2644E	Reserpine tab	0.25 MG	25	100	0A08691		2.90	2.90		3095329
Sept. 29, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.65	1.65	77	2905980
Sept. 24, 1969	0A10714	26	RX-3-9811B	do	Equip**	UTD	1	0A08691		1.60	1.60	77	2805205
Do	0A10714	26	RX-3-9830A	Urine bags		UTD	1	0A08691		5.96	5.96	77	2805206
Sept. 23, 1969	0A10714	26	RX-3-3504A	Hydrochlorothiazide	25 MG	30	60	0A08691		4.22	4.22		2805207
Sept. 17, 1969	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.60	1.60	77	2735194
Do	0A10714	26	RX-3-9830A	Urine bags		UTD	1	0A08691		3.30	3.30	77	2735063
Sept. 9, 1969	0A10714	26	RX-3-1500F	Pilocarpine Oph Sol 1 percent	15 CC	37	15	0A08691		3.40	3.40		2735062
Do	0A10714	26	RX-3-9811B	Other drainage	Equip**	UTD	1	0A08691		1.60	1.60	77	2735065
Do	0A10714	26	RX-3-9830A	Urine bags		UTD	1	0A08691		2.63	2.63	77	2735064

Sept. 3, 1969	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2735066
Sept. 2, 1969	OA10714	26 RX–3–3307B	Methyldopa tab	25 OMG	25	100	OA08691		8.30	8.30			2735067
Aug. 26, 1969	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2905964
Aug. 19, 1969	OA10714	26 RX–3–9007C	Neomy, Bacit, Polymyxin	Powder	UTD	82	OA08691		5.00	5.00			2905959
Do	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2905958
Aug. 12, 1969	OA10714	26 RX–3–1500F	Pilocarpine oph sol 1 percent	15 CC	UTD	15	OA08691		3.40	3.40			2905960
Do	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2905965
Aug. 5, 1969	OA10714	26 RX–3–6331A	Insulin-NPH, PZ, LEN, GLOB	U40	UTD	10	OA08691		1.48	1.48			2905963
Aug. 4, 1969	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2905961
Do	OA10714	26 RX–3–9830A	Urine bags		UTD	1	OA08691		5.63	5.63	77		2905962
July 30, 1969	OA10714	26 RX–3–3307B	Methyldopa tab	250 MG	25	100	OA08691		8.30	8.30			2165341
Do	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2315645
July 25, 1969	OA7243	26 RX–3–0166A	Sulfamethoxazole tab	0.5 GM	30	60	OA08691		9.50	9.50			2165835
July 24, 1969	OA7243	26 RX–3–1500H	Pilocarpine Oph Sol 1 percent	30 CC	UTD	15	OA08691		2.50	2.50			2165836
July 23, 1969	OA10714	26 RX–3–9007C	Neomy, Bacit, Polymyxin	Powder	UTD	3	OA08691		6.35	6.35			2165337
Do	OA10714	26 RX–3–9804C	Clinitest tab	1,000's	UTD	100	OA08691		4.35	4.35	77		2165340
Do	OA10714	26 RX–3–9811A	Catheters		UTD	1	OA08691		5.63	5.63	77		2165339
Do	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2165338
July 22, 1969	OA7243	26 RX–3–6331A	Insulin-NPH,PZ,LEN,GLOB	U40	UTD	10	OA08691		1.50	1.50			2165837
July 16, 1969	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		5.65	5.65	77		2165335
Do	OA10714	26 RX–3–9830A	Urine bags		UTD	1	OA08691		3.30	3.30	77		2165336
July 15, 1969	OA10714	26 RX–3–9811B	Other drainage	Equip**	UTD	1	OA08691		1.60	1.60	77		2165334
May 7, 1969	OA10714	26 RX–3–1500F	Pilocarpine Oph Sol 1 percent	15 CC	37	15	0C24963		3.40	3.40			1297937
Jan. 28, 1969	0D11478	26 RX–3–9114B	Flurandrenolone 60 GM	.0251	AAB	60	0C24276		5.20	5.20			0501143
Dec. 20, 1968	0D11478	26 RX–3–9110B	Fluocinolone CR-Oint 0.01	60 GM	AAB	60	0C24276		5.30	5.30			0170583
Do	0D11478	26 RX–3–9114B	Flurandrenolone 60 GM	.0251	AAB	60	0C24276		5.20	5.20			0170581
Nov. 7, 1968	0D11478	26 RX–3–9110B	Fluocinolone CR-Oint 0.01	60 GM	AAC	60	0C24276		5.30	5.30			1639920
Do	0D11478	26 RX–3–0016E	Elastic bandage	4 inches	UTD	2	0C24276		5.20	5.20			1000021
Oct. 21, 1968	0D11478	26 RX–3–0010B	Fluocinolone CR-Oint 0.01	60 GM	AAC	60	0C24276		5.30	5.30			1661293

Dr. BRAMHAM. This testimony is devoted to our development of a program for the control of hospital admissions and stays based on preadmission and concurrent certification as to admission necessity and appropriate length of stay. The plan is referred to as the certified hospital admission program, or CHAP.[1] It is a system which is working well for us, and we feel that others interested in peer review should be aware of it.

The recent and rapid escalation of costs and demand for health care services has caused as much concern to the 900 member Sacramento County Medical Society as it has to the Nation's medical and legislative leaders. Our Sacramento Medical Society has been active, through its medical care foundation, in establishing minimum standards for adequate and realistic health insurance in our community. At a time when we wished to be developing more innovative and comprehensive health plans, we were faced with rapid premium increases and benefit costs in the plans we now sponsor—without any upgrading of benefits themselves.

Early last year I gave our foundation's research and development committee the seemingly impossible assignment to find a way to increase benefits in our commercial programs, including better outpatient care coverage, preventive care coverage and psychiatric care, plus full coverage for hospital and maternity without any increase in premium. With all of this, the patient was to retain freedom of choice of physician and hospital. Needless to say we had many joint meetings with our foundation staff and with representatives of the Sacramento-based California-Western States Life Insurance Co.

We explored many possible avenues of cost control but always came back to increased control of hospital costs as the one factor which could offer the greatest possibility in reaching our goal.

Working closely with the administrators from eight of Sacramento's principal private and commercial hospitals, we started an evaluation of possible ways of reducing hospital expenses. The hospitals were very concerned about retrospective, or "after-the-fact," utilization review, which frequently denied or reduced payment of hospital costs after the services had been rendered. We knew the unhappiness and the anger experienced by patients who had to pay unexpected hospital bills because of such retrospective utilization review, many times months after the provision of services.

The experience of both our foundation and medical society insurance review committees has been that this "after-the-fact" review tends to extend economic protection to the patient and the hospital because such retrospective claims brought to the committee are after the bill had been incurred. At such post-facto time it is much more difficult to deny payment when the patient believed that he had coverage because no one informed him otherwise. It then seemed obvious to us that the next step was to develop an effective prospective or current utilization review plan. A system was thus developed that would allow prehospital certification on elective admissions, and current evaluation of emergency or of urgent cases, a logical extension of long-established local medical peer review programs aimed primarily at physicians' fees.

[1] See app. C.

The first important requirement of this system is the use of registered nurses hired by the foundation to follow all of the plan's patients both before and during hospitalization. She must follow the daily progress on hospitalized patients because:

1. Many times a diagnosis changes, especially during the first few days in the hospital;

2. Many times the patient can be discharged at an earlier date than is traditional or the patient personally desires and

3. Sometimes, even though the patient has a bona fide illness, acute in-hospital care is not necessary.

The second major requirement is a cooperative group of physicians knowledgeable and experienced in peer review to work with the foundation's nurse coordinators. Our nurses currently average 200 telephone calls per week to the panel of foundation-retained claims review physicians to determine medical necessity of hospitalization, length of emergency stay, or length of extension when required.

The third major component is a system for keeping the hospitals and physicians informed of the program and securing their continuing cooperation.

The elective patients, such as the tonsillectomies that Dr. Harrington was referring to, are certified before admission. The emergency cases are certified as soon as possible after admission. On all cases the nurse coordinator confirms the admission diagnosis and patient age by chart review, by discussion with the ward nurse and, when necessary, with the attending physician. She then certifies the hospital length of stay based on the 50th percentile reported in the current Ann Arbor Professional Activities Study, referred to as PAS.

The PAS 50 percentile is the stay of an average patient by age and diagnosis. This compilation is a nationally recognized study of over 16 million hospital discharges from almost 1,000 hospitals throughout the country.

We are currently making some local modification in the PAS toward shorter certification periods based on our experiences to date. Thereafter extensions are given so long as hospitalization is medically necessary.

Any time the nurse coordinator feels that hospital care is not medically necessary she contacts the appropriate foundation review physician and attending doctor to establish length of stay.

We have provision for chart and bedside consultation and immediate appeal when the attending physician and foundation review physician cannot agree.

I would like to give you a few brief results of our CHAP activity so far. Our foundation has sponsored a commercial program for a 2000-life group based on the certified hospital admission program since October 1, 1969. I am happy to report that we did achieve our original goal of dramatically increasing benefits, particularly outpatient services, without increasing premium to the employee or his plan. As a matter of fact, a significant reserve is accruing to the plan to add even more benefits.

In spirit of these increased benefits and because of CHAP, we have reduced average length of hospital stay in this group from 6.6 to 5.6 days.

Therefore, due to our experience with preadmission certification,

and at our request, the California Department of Health Care Services worked closely with us in establishing similar program for all medicaid patients in Sacramento County—approximately 70,000 recipients—beginning on April 13 of this year the department had ordered medicaid preadmission authorization to begin statewide on that date with the authorization to be made by nonpracticing, State-employed medical consultants. Since we already had such a program in effect, we requested to carry out the directive ourselves and the department agreed. CHAP in Sacramento, under medicaid, involves not only 10 private and community hospitals, it involves the 650-bed county hospital which is the only teaching hospital for the University of California at Davis Medical School. It also involves the Kaiser-Permanente Hospital for a total of 12 facilities.

We have, so far, reduced the average length of stay for medicaid patients from about 6 days to 4½ days, in Sacramento County under this program.

Put another way, initial figures reported back to us from the State show that we have reduced the number of hospital days per 1,000 medicaid recipients per year from a rate of over 1,200 to about 600.

Because of this dramatic demonstration of savings without compromising on patient care, the State is now working to extend this program throughout California for medicaid patients.

The next logical extension, we believe, is to develop a similar program for medicare's hospital and extended care facility patients.

This, then, is the basic concept of a certified hospital admission program. It is a working and successful program. It is being successfully applied to both private and government programs. It can significantly reduce the cost without compromising quality of health care or a physician's direction in the care of his patient.

I would like to thank you for the opportunity of appearing before this committee. We would be pleased to answer any questions the committee may have concerning either the Sacramento or San Joaquin Foundation programs.

Senator Anderson. Senator Williams.

Senator Williams. Doctor, I understood you to say that as a result of your project you had cut hospital usage in half, from about 1,200 to 600 days per 1,000 people per year.

Dr. Bramham. There are two factors involved in that statement. One is actual length of stay. This we have cut, but not in half. The other factor is number of hospital admissions. Patients are not now being admitted to the hopsital for procedures possible as an outpatient. So the combination of those two factors has, to date, resulted in a 50 percent reduction in medicaid hospital use under CHAP in our community.

Senator Williams. What percentage of the requests by physicians for approval of hospital admission have you rejected?

Dr. Bramham. I don't have an exact figure on that percent at this time. Probably at this point it is not more than 1 to 3 percent, but there is a "discouragement effect" in the program because the physician knows that he needs to justify the hospitalization. We don't deny any necessary hospitalization. But if a doctor and patient know that the patient can't be hospitalized for the convenience of either, or the doctor realizes he cannot get away with poor quality medicine—or medicine

not up to community standards—he is not going to ask to have the patient admitted.

Senator WILLIAMS. Well, I appreciate that. I appreciate the testimony of yourself and Dr. Harrington, too. It is a great help to us in studying this program, which we all recognize is open for review. We want to work together and make whatever corrections are necessary in order to protect those who pay for the program as well as those who are using it. Because time is running late, I was wondering if you would mind waiting after this is over and answer a series of questions that the staff would want to present to you. They are questions that I think will help us in our work as a committee.

If you have the time we would appreciate your cooperation.

Dr. HARRINGTON. I am sure we will all be happy to stay.

Senator ANDERSON. I must say it is fine report. I congratulate you on it. I see some possibility of real solutions to our problem. You and your foundations have done a very good job.

Senator WILLIAMS. I agree that this is the kind of report and the kind of testimony needed in this committee to get corrective measures.

Dr. HARRINGTON. Thank you.

Senator ANDERSON. The Pennsylvania Medical Society.

Go ahead, doctor.

Dr. MARSHALL. Thank you, Senator.

STATEMENT OF DR. MATTHEW MARSHALL, JR., CHAIRMAN, PENNSYLVANIA MEDICAL SOCIETY'S COUNCIL ON MEDICAL SERVICE, PITTSBURGH, PA.

Dr. MARSHALL. I am Matthew Marshall, Jr., of Pittsburgh, the chairman of the Pennsylvania Medical Society's Council on Medical Service and I appear here today as its representative to describe our efforts to make medicare and medicaid as efficient as possible and to present recommendations for improvements. I am in the private practice of urology and I have been deeply involved in working with third parties, especially in the utilization and review area, for more than 12 years.

I am also authorized by Dr. Edward H. Hale to say that the Keystone Medical Society endorses and concurs in general with the position paper of the Pennsylvania Medical Society as presented here.

Immedicately following the passage of medicare, the Pennsylvania Medical Society sponsored, along with the State office of medicare, a series of seminars across the State to familiarize physicians and their office assistants with the new program. Since that time, we have maintained close liaison with the State agency, the Social Security Administration, Bureau of Health Insurance, Blue Shield, the Blue Cross Plans, and the Travelers Insurance Co.

It is obvious that there were and continue to be problems but I am sure that our joint efforts in Pennsylvania have minimized them. For example, the implementation of the medicare program with its many inherent complexities made it necessary for the Bureau of Health Insurance and the fiscal intermediaries and carriers to recruit and train many additional—and inexperienced—employees. In view of this tremendous "tooling up," we feel that the performance of the carriers and intermediaries in Pennsylvania and the Bureau of Health Insurance have been relatively commendable.

The goals of peer review activities have been the subject of considerable discussion recently. There have been references that failure of utilization committees to control costs has been a major reason for increased hospital costs. We will describe briefly some of our experiences, dating back to 1958, in developing various peer review mechanisms. In this discussion, it is important to clarify the substantive differences between "claims review programs," which are often misnamed "utilization review programs," and "hospital utilization review programs."

In a "claims review" activity, the focus is on an individual case whereas with "hospital utilization review" the goal concerns the total pattern of admissions, stays, and procedures of an institution.

The motivation and methodology of committees of physicians engaged in claims review is quite different than those involved in utilization review. In claims review, the committee is concerned with the appropriate administration of health benefits. In utilization review, the goal is the most appropriate use of institutional facilities. In claims review, the cost effect is immediate. In utilization review, health care costs are affected only after the period of time that is required for the committee recommendations to be considered and approved or rejected as part of the factors in determining the future nature and scope of services an institution may offer.

If you look at the material the hospital utilization project has prepared you will notice, for example, there has been a reduction in the average length of stay for maternity cases while at the same time the occupancy rate has not increased very substantially. The reason for this is there are fewer beds devoted to this particular service, and this is where the savings come in.

If, for example, the admission rate or the length of stay had been reduced substantially without adjustment to the number of beds available we would be finding the public would in one way or another have to continue to pay for the cost of the empty beds.

On the other hand, insofar as the immediate payer is concerned with that particular claim, no savings would be apparent. This is what we really mean by pattern of review and I think, as will be apparent from those statistics, this will hardly be due to one factor alone where we have hospital planning associations, and there were many other factors to take into consideration as to how a community handles its hospital beds.

For example, the people in San Joaquin were talking primarily about claims. This is important but utilization pattern review is also important and it is different.

Senator ANDERSON. You heard the San Joaquin presentation?

Dr. MARSHALL. Yes, sir.

Senator ANDERSON. Do you have any comment on that?

Dr. MARSHALL. Yes, sir. I think what we have said, as you look over our statistics and our program, that there are many similarities between what I would consider to be the claim review programs of Blue Shield or Blue Cross in Pennsylvania and what the San Joaquin people are doing except they are handled in separate agencies. But 12 years ago when we got into our problems in Pennsylvania we had to make a basic decision as to whether we were going to put the effort of the Pennsylvania Medical Society in supporting the institutions which we had such as Blue Shield, Blue Cross, the commercials, the Mine

Workers, or whether we were going to try to set up our own plan, and our efforts have been primarily directed in a way that shows many similarities to theirs but by trying to make Blue Cross and Blue Shield more successful rather than setting up our own plan.

Senator Anderson. Thank you very much for your comments.

Dr. Marshall. Both claims review and utilization review are important, but to assume they are identical leads to confusion.

Such confusion apparently existed at the time the medicare law was developed, but this is understandable since both concepts were relatively new at that time.

Many of the current judgments that hopsital utilization committees are performing poorly arises from a lack of understanding of their function within the law. They have not achieved the state of perfection but specific guidelines hardly can be written to assure perfection. However, progress under medicare in developing meaningful utilization committees has been much faster than the progress, if any, made by the Veterans' Administration—a totally federally controlled and regulated comprehensive multispecialty group practice health plan. Improved performance can be obtained by providing guidance with latitude to motivate utilization committee members, hospital administrators, fiscal intermediaries and agencies, such as the hospital utilization project, to work together to meet this challenge of more effective use of health care dollars. With respect to that statement we have some HUP statistics showing about 10 diagnostic categories from large hospitals over 350 beds. This includes the Veterans' Administration at the time they chose to participate, and it shows you there are varying degrees of efficiency, if that is the proper word for it, as measured by average length of stay, and the relative length of stay is not uniform in each hospital; some may be shorter in one diagnostic category than in another.

The Pennsylvania Medical Society has established claims review programs, in cooperation with Pennsylvania Blue Shield, for part B medicare beneficiaries; and with Blue Cross and Travelers Insurance Co. for hospital and extended care benefits. Pennsylvania Blue Shield, including medicare, deals with about 8 million subscribers. In conjunction with the Hospital Council and Blue Cross, we established the hospital utilization project—HUP—to assist hospital utilization committees in performing their basic functions. Our joint efforts also resulted in much progress in encouraging utilization committee development.

Dr. Lewis and Dr. Schein are not with me as I anticipated but I will be glad to go over in more detail the matters of detailed review and the matters of the hospital project in this presentation.

The Pennsylvania Medical Society will continue to work with all persons and agencies concerned in the development of a better medicaid program. To date, the program in Pennsylvania has been understaffed and underfunded and it depends upon the willingness of physicians to perform services at or below their overhead costs at a 1948 fee schedule, or without any charge, in order to avoid the paperwork involved. We have recommended that Blue Cross and Blue Shield underwrite the entire medicaid program. This would be a major step in removing the so-called "medical assistance" stigma, by making each recipient a card-carrying Blue Cross-Blue Shield subscriber on a basis comparable with 5 million other such subscribers in the State. We

also have recommended greater flexibility so that the program might deal more effectively with those urban and rural areas where there are large concentrations of eligible recipients.

The Pennsylvania Medical Society, believing that all of our residents are entitled to quality medical care, believes that legislation is required to assure that all employed persons have a voluntary health care plan that is at least equal to existing Blue Cross and Blue Shield plans. We support the AMA medicredit plan as a means of accomplishing this objective. We believe the needy should have a plan that allows them to compete effectively with more affluent citizens in obtaining needed health care services. For that reason, we have supported a prevailing fee plan for medicaid but it has never been fully implemented. Apparently the more affluent majority of citizens will not support sufficient tax revenues to achieve this objective so that today most of the needy in Pennsylvania continue to be dependent upon the charitable intention of physicians and other health care providers.

I might add that currently in Pennsylvania we are down to the point where about a dollar a day may be all a person gets for room, board, clothing and the necessities of life, but this does not include medical care. This amount of slightly over a dollar a day may make poor patients ever more concerned with existence than about medical care when they are down to that kind of subsistence allowance.

I stress that subsidization by physicians currently is required for the medicaid program to be operable in Pennsylvania. Failure of the legislature and the public to recognize this present state of affairs impedes the development of the maximum cooperative effort required if we are to achieve the goals of better health care for the needy.

Obviously a major purpose of this hearing is to find ways by which the cost experience of the medicare program can be changed by reducing the inflationary trends of health and medical care costs. Medicare obviously helped resolve problems of enrollment, underwriting, and individual costs of the aged, but it has proven to be both costly and frustrating for patients and their relatives, and for physicians and other providers of health care, as well as the intermediaries.

I believe that the basic defect in the medicare law is that it is oriented to the provider to carry out the specifics as determined by Congress. Apparently it was designed primarily on the advice of a relatively few "expert" providers of medical care and "experts" in the theory and administration of the delivery of health care rather than upon the documented variety of demand as perceived by consumers of health care. In the final analysis, it is difficult to deny the public what it wants in the matter of priorities for health care expenditures. Provider concepts of necessary medical care, medically unnecessary custodial care, or even misuse, need public acceptance and understanding to be appropriately applied.

Experts can appropriately help the public in understanding health care needs and can suggest areas for health care expenditure efficiencies. However, their cost projections can and have been wrong and their ability to define what is appropriate or inappropriate medical care for the public has differed from the public demand. As an example, there is the prediction that extended care facilities could be a significantly less costly alternative to hospital care, or that a clear distinction between medical care and custodial care in extended care facilities could be made to assure the proper use of such facilities.

Real incentive for better cost controls and planned effectiveness seems to depend upon a more consumer-oriented plan where the consumer would have a choice of intermediaries, each of whom would be given latitude to organize and underwrite the plan to meet the beneficiaries' demand for the services they feel they need at the lowest possible cost. The result would be a competition among the intermediaries for potential enrollees, a competition that holds the greatest incentive to achieve utilization and cost goals. This is a change recommended by the Pennsylvania Medical Society and it is similar to one recommended by Dr. Victor Fuchs, Ph. D., vice president of research for the National Bureau of Economic Research.

It is hoped that the Senate will recognize that there are limitations to the effectiveness of regulations and that regulations increase both costs and the demand on manpower necessary in physicians' offices to implement them. In the attached memorandum to Mr. Wolkstein of the Bureau of Health Insurance, I have set forth a number of areas where I believe that Blue Shield of Pennsylvania could be encouraged to experiment in ways to increase the cost effectiveness of their plan. Yet congressional action appears to be more in the direction of shifting the cost to the patient by increasing the percentage of physicans' fees the patient will have to pay by lowering the allowable percentile in part B payment calculations.

Your staff has indicated that the key to making the present system workable and acceptable is the physician and his medical society. This highly complicated lock appropriately awaits the key in the person of the busy physician. Despite the billions of dollars in medicare moneys, it is significant that the solution is said to rest in physicians giving extra, unpaid time to increase the effectiveness of health care financing systems. I believe that this may well be a correct—though somewhat paradoxical—assumption. The progress that we have made with Blue Cross, Blue Shield, and government officials most often has resulted from the extra unpaid efforts of physicians, often during the off-hours of these officials.

Thank you for allowing me the privilege of appearing here today.

Since Dr. Lewis is not here, I would appreciate the opportunity of quoting from the testimony which he was planing to give if I could have your permission to do so. Some of it may be repetitious of what I have given and I would like to eliminate such points.

Senator Anderson. We will make that testimony a part of the record.

Dr. Marshall. Thank you.

(The testimony of Dr. Lewis and attachments to the prepared statement of Dr. Marshall follow. Hearing continues on page 697.)

Utilization Review in Pennsylvania

(By Paul M. Lewis, M.D., Executive Director, the Hospital Utilization Project)

I am Paul M. Lewis, M.D., of Pittsburgh, Pennsylvania, Executive Director of the Hospital Utilization Project (H.U.P.), a voluntary, non-profit, Pennsylvania corporation with headquarters at 3530 Forbes Avenue, Pittsburgh, Pennsylvania.

The following testimony is intended to acquaint this Committee with the nature and extent of the process known as utilization review, which is but one of the voluntary efforts by which Pennsylvania doctors, hospitals and other health facilities have attempted to insure the provision of high quality medical care in a manner consistent with the public interest. Increasing public awareness of the problems of delivery of health services is obviously related to concern with rising costs, greater demands for services, and the increasing role of governmental and

third-party payers. Unfortunately, it is equally obvious that simple identification of these problems does not always provide solutions that can be either simply or universally applied.

The basic concept underlying the organization of medical staff utilization committees is that health care facilities will be used more effectively if physicians assume the responsibility for self-evaluation and thus understand the factors that influence their utilization practices. A utilization committee that functions effectively and whose findings and recommendations are appropriately implemented by the health facility's administration can provide assurance that those patients admitted required admission, that the services ordered and provided were consistent with the standards of high quality medical care, and that the utilization of the facility was appropriate to the patient's medical needs.

Long before Medicare and Medicaid, Pennsylvania had received national recognition as a pioneer in the development of hospital medical staff review committees charged with the responsibility of scrutinizing the appropriateness of hospital use. As far back as 1954 reference had been made to appointing a "hospital utilization committee" to do in the field of hospital and medical economics what the tissue committee does largely in the field of surgery. One of the first general establishments of such committees occurred in 1959, when they were formed in most hospitals in Allegheny, Beaver, Lawrence and Westmoreland Counties, an area which comprises the Tenth Councilor District of the Pennsylvania Medical Society. The medical societies of these counties recognized the physician's role in hospital use and felt strongly that any mechanism for assessing this use should be devised and maintained by the medical profession. Therefore, the stated function of the new "utilization" committees was to insure provision of high quality medical care at reasonable cost through a system of physician review guided by established standards, to provide for control of misuse of hospital facilities and to stimulate progressive improvement in performance.

When these Western Pennsylvania hospital utilization committees began functioning in 1959, their general acceptance and early success stemmed from top-level medical society sponsorship and endorsement and the support of the Hospital Council of Western Pennsylvania. Obviously, all was not smooth sailing from the start, but, as the program developed, the concept of peer review gradually became better understood and more widely accepted within the medical community. Between 1959 and 1962, however, certain problems with the review process became apparent. It was manifestly impossible to review all cases or all aspects of medical care, and busy practicing physicians increasingly complained of much valuable time spent in essentially unproductive case review. It appeared that some method was needed to screen out cases that did not need review so that utilization committee time could be spent more productively discussing utilization practices and matters involving medical judgment.

Thus, in late 1962, after several years in which hospitals and their medical staffs had voluntarily contributed thousands of hours to programs of self-analysis and self-criticism, it seemed that survival of these activities depended on finding a more efficient and productive approach. Fortunately, local medical society leaders had not lost faith in the need for physician review of hospital use or lost hope for its success. Their determination to see that utilization review committees would continue to be viable and functioning led to the establishment of a centralized service organization, designed to assist hospitals and their medical staffs through statistical support and central staff consultation.

This organization, known as the Hospital Utilization Project (H.U.P.), began operation in January, 1963, under the co-sponsorship of the Allegheny County Medical Society Foundation and the Hospital Council of Western Pennsylvania.

Initial funding was obtained from more than 30 leading industrial, financial and philanthropic organizations in Western Pennsylvania and the local medical societies, while Blue Cross of Western Pennsylvania contributed valuable technical assistance in devising the methodology of H.U.P. and for the first four years provided the necessary data processing facilities without charge.

H.U.P. was designed as a voluntary, regional service to provide statistical and comparative data on hospital use as well as a variety of personal, in-hospital assistance in all aspects of utilization review activity. It began operation as a pilot study involving 14 hospitals in the immediate Western Pennsylvania area, but following endorsement of its program by both the Pennsylvania Medical Society and Hospital Association in 1967, expanded throughout the State and now has over 80 participating hospitals in all areas of Pennsylvania. Since the enactment of the Medicare law, the value of H.U.P.'s service to hospitals has been

recognized by the Social Security Administration which accepts the Project's charge for service as a reimbursable cost to hospitals and, in Pennsylvania, the same situation exists under the State's Medicaid program. Furthermore, the Department of Public Welfare, in its model utilization plan for hospitals, describes the H.U.P. technique as the method of choice.

This technique attempts to overcome the problems and limitations that were apparent in the sampling and other case selection methods in use between 1959 and 1962. It is essentially a pattern review, by which medical information is collected on all discharged patients and by the use of modern electronic data processing specific major diagnostic groups are analyzed and data reported to reflect comparative experiences. The principle use of the collected data is envisioned as a screening device, designed to reflect patterns of care and direct attention to practices which might be modified for groups of cases.

The data collection process begins in the hospital's medical record department with the completion of an abstract of the medical record of every discharged patient. These are submitted to H.U.P.'s data processing center monthly, and from them its computer generates monthly lists of patients by diagnosis and by operation and a discharge analysis of patients by service. Semi-annually, the patient listings are summarized into indexes which fulfill the indexing requirements of the Joint Commission on Accreditation of Hospitals.

The semi-annual disease and operation indexes provide H.U.P. with data for comparative length-of-stay studies. Some 20 major diagnoses and operations were selected from among the most common causes of hospital admission, and for each of these all hospitals receives a comparatively length-of-stay report semi-annually. Participating hospitals have been divided into comparable groups according to size, staffing, etc. and receive only the reports pertinent to the group. The reports for each of the diagnoses list each hospital in the group by name and shows for each, and for the group, the number of cases reported in the six-month period, their average stay and the average stay for the previous six months.

Semi-annually, H.U.P. also provides each hospital with a set of three simple bar-graph profiles which graphically illustrate the hospital's average lengths of stay in relation to other hospitals in its group. One each of these profiles is prepared for medical-surgical, obstetric-gynecological and specialty diagnoses. The comparative reports and profiles thus present the utilization committee with a focus on utilization experiences at variance with the community—not to indicate these experiences were wrong, but to stimulate the asking of "why?".

To help the utilization committee determine the answer to this question, H.U.P. provides them with detailed worksheets with which to do reviews of individual cases in the deviant categories. These individual reviews are intended to be done prior to the monthly committee meeting, at which the worksheets are used in discussion of specific utilization problems and in evaluation of quality of patient care. Abnormally long length-of-stay experiences are frequently identified as due to the medical care needs of the patients in the period in question. In the process of review, however, administrative inefficiencies can be identified and recommendations made for correction, while physician habit patterns not related to quality of patient care can be analyzed and suggestions made for possible revision.

In January, 1967, this concept of physician review of proper use of health facilities was mandated by the Medicare law to be applied in a newly designated type of skilled nursing home certified as extended care facilities. Regulations under the law prescribe certain utilization review procedures which must be applied at least to Medicare patients of each facility. Since many extended care facilities have no formal medical staff, the Tenth Councilor District of the Medical Society joined with Western Pennsylvania Blue Cross to organize and offer a co-operative utilization review program known as the Central Review Plan. H.U.P. was asked to develop a specialized medical reporting abstract for this Plan, as well as a data collection and reporting system suited to the capabilities and needs of these facilities.

The Central Review Plan is conducted by volunteer physicians from the Medical Society and performs utilization review for about 35 extended care facilities not having their own committees. For the past three years the medical abstracts of all Medicare patients reviewed by the Central Plan and all reviewed in 15 other facilities using their own committees have been submitted to H.U.P. for analysis. This program, which is funded under a contract with the Public Health Service, provides all participating facilities with periodic comparative and illustrative data as to patients and their needs, services provided, and the like.

In summary, the foregoing activities represent but one of many sincere attempts to insure that the people of Pennsylvania receive high quality health care in a manner consistent with their needs. For more than a decade these and other programs dedicated to the same ends have received the continuing support of physicians, hospitals and Blue Cross of Pennsylvania, the major third-party payer of health care expenses. It must be borne in mind, however, that there is no single magic device for assuring appropriate hospital use. Many inter-related and sometimes conflicting factors affect hospital use and costs, such as increased public demand for services, socio-economic factors, the supply of hospital beds, the organization and availability of alternative facilities, etc. Physician review of proper hospital utilization practices can obviously play only one role in the interplay of these multiple forces. Its value as an educational device, however, is unquestioned, and it has won general voluntary acceptance by the health professions as one of several necessary mechanisms to assure proper use of public money spent for hospital care.

PENNSYLVANIA MEDICAL SOCIETY,
COUNCIL ON MEDICAL SERVICE,
Lemoyne, Pa., January 7, 1970.

MR. IRWIN WOLKSTEIN,
Assistant Director, Division of Policy and Standards, Bureau of Health Insurance, social Security Administration, Baltimore, Md.

DEAR MR. WOLKSTEIN: I appreciate our recent visit with you, Mr. Tierney, and other members of your staff. Thank you for sending me your perceptive article regarding incentive reimbursement plans in the Journal of the American Hospital Association. I believe there is a genuine desire not only on the part of the Pennsylvania Medical Society, but others involved with the Medicare program to overcome the multiplicity of overwhelming problems that Medicare seems to present, and that the development of incentives is an attractive approach.

The title of your paper is particularly encouraging since it indicates a desire to emphasize the positive and objective approach rather than depending upon the more negative and over-used approach of regulations to prevent abuse and relying on subjective opinion as to what is best for the public.

To me, the problem in developing effective incentive reimbursement plans lies with the basic defect in the Medicare law in that it is entirely a "provider" oriented plan carrying out the specifics as determined by Congress for the people. Real incentive in this direction would seem to depend upon an orientation toward the consumer having available a choice of intermediaries, each of whom would be responsive to a demand for more or better services, the type most desired, and at the least cost, and each of whom would have much more latitude to organize and administer the program in the way they felt most effective. This is the change recommended by the Pennsylvania Medical Society and is similar to that suggested by Dr. Victor Fuchs. I realize that no present legislation in this direction is contemplated, but I hope it can be given more serious consideration for it appears to be the most promising method of controlling increasing health care costs.

Obviously, if incentive reimbursement plans are to be proposed as approaches to cost control and an understanding of the nature of incentives is required. As you pointed out, this is quite complex and financial incentives are often of secondary importance. This is particularly true of those responsible for policy decisions in the health care field.

In my opinion, incentive in the health care prepayment field depends primarily upon a recognized potential success in advancing the status of their particular health care plan and its philosophy in the eyes of those they consider to be their peers. They recognized that it also depends upon success in enrollment and in effectively meeting the needs of both the providers and consumers identified with the plan. If this is an acceptable premise, it would seem feasible to encourage experimentation within the current law by allowing greater opportunities for variation in administration. Priority should be given to eliminating the detailed regulations that seem to have caused unnecessary confusion, waste manpower, and increase cost if they can be replaced by an acceptable alternative, proposed by the plan that would accomplish the same objectives. Similarly, projects designed to improve mechanisms of evaluation of cost or service, and the development of processes for handling data received, would be in order since it is most

important to develop a better basis for comparison. In a sense, Western Pennsylvania Blue Cross and the Pennsylvania Medical Society have progressed in this direction inasmuch as the Medicare Review has been integrated with the MAC review. Such streamlining should save costs of the fiscal intermediary, produce more efficiency by simplifying and streamlining the tasks for physicians. I would think that the Social Security Administration could have some interest in providing the funds to determine the effectiveness of this type of approach.

The problems of administering the extended care facilities section of Medicare are, of course, compounded by the problem of lack of previous experience in administering such a benefit that is defined in a way that really defies development of medically understandable guidelines. However, I do not believe that you will find anywhere in the country, a medical society with a central review plan working more closely with the fiscal intermediary than Western Pennsylvania Blue Cross and the Hospital Utilization Project trying to solve this multi-faceted dilemma. For that reason, I would hope that Social Security will do all it can to see that the Hospital Utilization Project can continue to work with the ECF to develop ways to evaluate use and effectiveness of extended care facilities so further study of our problems could lead to a better basic understanding of what is needed. In other words, in the ECF field, it would appear that a better basic understanding of what is required and what the public demands is needed before a more logical approach to incentives can be developed. And this is why I feel the Hospital Utilization Project and the Extended Care Facilities Project should be recognized to have greater importance than they are now given.

In the case of out-patient services, the methodology for developing, review processes for large numbers of claims was, of course, nearly non-existant prior to Medicare, and a better understanding of these techniques is only now developing. As discussed with Dr. Bedwell, we are developing in conjunction with Blue Shield, a multiple cycle method of review which may well warrant an expenditure of additional funds to develop mechanisms for comparing the effectiveness of various mechanisms. A similar project would be the question of determining whether an 83% percentile of charges or a 90% percentile of physician's fees is a more appropriate basis for calculating acceptable maximum limit of fees. As I indicated, in my opinion, often a minority of physicians who have unusual patterns of care may have large volumes and large fees in a particular category, and thus, would have an unjustified effect upon cost that would not be the case when the basis is physicians' fees. I believe that the Pennsylvania Blue Shield is making real progress toward resolving the difficult problems associated, and I feel with maximum fee determination, that an experiment to document the difference in effect of the two methods of calculations would be worthwhile by giving a more objective basis for current differences of opinion. It might well resolve the problems to everyone's satisfaction.

I believe that Paul Lewis will be down to talk to you people rather shortly, and if there are any of these other approaches which you feel you might want to pursue, please let us know.

Very sincerely yours,

MATTHEW MARSHALL, JR., M.D.

[From Hospitals, J.A.H.A., June 16, 1969]

INCENTIVE REIMBURSEMENT PLANS OFFER A VARIETY OF APPROACHES TO COST CONTROL

Incentive reimbursement plans sometimes fail to restrain increases in health care costs because the incentives are not efficiently applied or because other incentives are more compelling, the author says. He describes a number of financial incentive proposals now being tested and the potential results in savings of the various plans.

(By Irwin Wolkstein)*

Incentive reimbursement consists of inducements that are built into the process of paying for health services to keep the payments per unit of health service output as low as possible. To complicate the problem of achieving this goal,

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health services output is difficult to define and even harder to measure. Qualitative differences are the essence of the matter in health care since an increase in quality may change a valueless service into a substantial contribution to health. Yet quality of care is virtually unmeasurable in the present state of knowledge.

Reimbursement incentives are incorporated into the health system as it now operates. The problem of health care reimbursement is sometimes described in terms of a case where the provider of services gains most when his costs are highest—that is, if cost-plus reimbursement is paid, the provider is very wasteful because the more he wastes the more he makes. And in the extreme case the patient is completely unconcerned about costs—in fact he prefers the most expensive service—because he doesn't pay the bill himself; an insurer or the government pays, and the patient saves nothing by choosing less costly care. This extreme case does occur in real life, but not for the greater part of medical care.

Much of medical care still is provided on the basis of charges, so the health service industry is subject to many of the pressures for efficiency that are applied to other industries. Furthermore, although the incentive to the individual buyer to purchase health service with an eye to price has diminished as the proportion of care paid for by third parties has increased, about two-fifths of all care still is paid for out of pocket. In addition, when a third party pays for care, that party is not unconcerned about prices. The third party may, in fact, put into effect restrictions on what it will pay that may be equal to or more effective than the shopping practices of individual buyers in minimizing the price paid.

Hospital administrators and other health service managers are as a group well intentioned in avoiding waste and do so sometimes to the extent of financial disadvantage to their institutions. However, health service managers have other objectives besides saving money. First, minimizing the risk of an error that may result in dismissal may be preferable to maximizing the likelihood of cost reduction. Second, administrators generally seek to spend funds in ways that will advance their organizations. The success and the incomes of hospital managers are closely tied to the success of the institutions that employ them. The problem is that expenditures that advance one organization may produce cost or quality disadvantages to the system as a whole. The difference between one hospital's point of view and the perspective of the entire system is illustrated by the frequently cited example of the proliferation of cobalt radiation equipment or open-heart surgery facilities—each institution may be better for having the facility but the system becomes less efficient and offers poorer quality care if the facilities become too numerous.

The point here is that there are a large number of incentives brought to bear in health care, some leading to and others leading away from higher costs. Some of the pressures that lead to ineffective practices will not be easily overcome. For one thing, a physician's livelihood depends on his hospital having the facilities that help him care for patients and he will not be satisfied if the demands can only be met in some other hospital by some other physician. To be successful, a hospital must attract highly qualified physicians and their patients. Pressure for duplication and an excess of capacity in hospitals will be strong so long as the excesses are advantageous to doctors and the cost of the excess falls only indirectly on patients through the premiums and taxes they pay.

INCENTIVE ISSUES NOT NEW

The issue of how to develop reimbursement methods to help keep costs low is not new. The issue arose when the mass purchase of health services began. A purchaser of a large quantity of goods from a single seller generally buys through letting bids or other such techniques and not paying the usual retail price. Various types of incentives to lower costs long have been included in third-party hospital reimbursement systems used in Canada and by Blue Cross Plans in the United States. Furthermore, group practice prepayment plans sponsored by consumers were developed around arrangements that were intended to lower costs for physicians' services.

Medicare legislation includes a number of incentive-related provisions that it was hoped would foster, or at least prevent interference with, continued effective operation of facilities. The very power financial incentive of basing Medicare payments on hospitals' ability to meet these requirements has secured almost universal compliance. If the requirements have not fully met their objective, the failure probably is not due to an ineffective incentive. The Medicare requirements include peer review of the use of institutional services and physician certification, both of which are intended to reduce the unnecessary use of services.

Another Medicare approach to avoiding misuse of services is to minimize the financial advantage to patients of using hospitals by providing coverage of extended care and outpatient services that offer adequate, less costly substitutes for hospital care. Medicare legislation also requires that participating hospitals must maintain cost records and report costs. This measure provides a basis for increasing knowledge about costs incurred. Public knowledge that an institution has higher costs might be an incentive to keep costs reasonable.

The final incentive bult into Medicare has been little used to date. The Medicare program has the authority to limit cost reimbursement to reasonable levels. Although this authority has not yet been implemented in substantial degree, it was intended to help inhibit excessively high costs. Some of the current efforts toward incentive experimentation may help establish ways to distinguish reasonable costs and to apply the findings in an effective manner. If such matters are found they are likely to be used.

ALTERNATE APPROACHES

This preface to describing current federal activities in incentive reimbursement would be incomplete if it did not indicate that there are a number of different approaches that can be taken in attempting to slow the increase in health care costs. One approach is to develop more cost-saving ideas which, if made known, would be adopted voluntarily. This approach is represented in some of the activities of the National Center for Health Services Research and Development, for example.

Another approach is to increase emphasis on planning and perhaps to provide for mandatory planning, such as in the Folsom Act in New York State. One possible means of making planning a more effective cost control tool would be to make efficiency of operations a criterion for construction grants, in order to support the expansion of the more effective organizations and, in making grants, to place more emphasis on projects that have the effect of lowering costs. The problem in relying on planning as it now operates to control costs is that planning has not yet proved very effective.

Another possibility is to have a board establish reimbursement rates for hospitals, as was proposed by Gov. Nelson Rockefeller of New York last year and as is practiced to a limited degree in Indiana, where hospital charges are fixed by a board that acts on hospital requests for hearings. This approach seems to be modeled on the system used for setting public utility rates.

Yet another possibility is for hospitals and purchasers to negotiate to fix the amount to be paid. This approach was proposed by the Secretary of Health, Education, and Welfare's Committee on Hospital Effectiveness and is incorporated in the *Statement on the Financial Requirements of Health Care Institutions and Services* adopted by the American Hospital Association.

Another approach is to seek to induce an increase in competition among providers of services. For example, an increase in the number of practicing physicians might contribute toward more effective competition. However, competition among hospitals is not in accord with the ideals of current planning concepts since competition by its very nature requires duplication of services, while planning principles assume that final costs will be minimized if unnecessary duplication is avoided. Since even the ideal competitive market does not always result in the most effective use of services, any substitute for market forces is likely also to fall short of producing perfect results.

A pertinent question here is what degree costs can be reduced by means of incentives without a concurrent reduction in the quality of care. Perhaps the best way to answer the question is to find a case in which an incentive system has been fully applied. It appears a reasonable assumption that where the ownership and control of a health service system are consumer-oriented, there would be a strong incentive to make the most of consumer funds—to pay attention to cost, quality of care, and service to the consumer. The Kaiser health system apparently comes close to meeting the consumer orientation criterion in a plan with comprehensive coverage.

The Health Manpower Commission has estimated that the Kaiser system is 20 to 30 per cent less costly for plan members than are comparable services for nonmembers in California. If one assumes that the services obtained by the two groups are equivalent in value, one could estimate that the maximum reward from incentive measures in this instance is a 30 per cent cost reduction.

MARKET FORCES

This example leads to the central issue here, which is that the idea behind incentive reimbursement is that the forces of the marketplace that work to lower

costs of nonhealth services do not perform adequately in the health field. Cost reimbursement to hospitals—especially cost-plus reimbursement—offers no built-in incentives to cost restraint. Competition apparently does not act very effectively to induce efficiency and to hold down prices of hospital and physician services.

Furthermore, the hospital portion of the health care industry is predominantly nonprofit or government-owned. Profits accruing to this type of organization are not so important as they are to private business. Funds for expansion come from sources other than retained earnings and the motivation of hospital management may be stronger to serve medical staff, patients, and potential donors than to maximize profits. The existence of these multiple incentives is a factor in the present problem.

Even in the case of physicians' services, the profit motive may not be as strong a factor as is popularly assumed. When income reaches a certain point, additional income from work—especially in view of the tax impact—may not be a powerful incentive that will lead to substantial emphasis on efficiency. In fact, some means of increasing physician efficiency, such as delegating certain tasks to less skilled persons or having them performed in a more efficient setting, may actually decrease the physician's income.

A change in the way medicine is practiced may remove some of the present inconsistencies between maximizing income and minimizing cost; however, the physican may be less strongly motivated by added profits than by his preference for his present method of practice.

Finally, cost savings obtained from increased efficiency may be retained by the physician rather than passed on in lower prices. In classical theory, the marketplace would provide a strong incentive to add recruits to a field yielding unusually high income so that competition might prevent excessive income. However, training requirements and other limitations on competition render it a relatively ineffective control on income in this field.

In the absence of effective forces of competition and strong emphasis on profit in the health field, the question arises as to what measures could be developed to bring additional marketlike forces into play. Almost no one wishes to apply additional government controls to the health industry, so there is a great deal of interest in ways of encouraging voluntary actions to reduce costs.

Acceptability is an important factor in developing proposals for change in view of the nation's tradition of consent of the governed. Although it is almost certain that no artificial incentive system based on voluntarism could produce effects equal to those produced by an ideal market, it is possible that factors can be developed that will add inducements to the various incentives now present.

NATURE OF THE TASK

The work currently being done on incentive reimbursement includes research into measures of output; investigation of the operating results of methods used in the past to provide incentives to efficiency; and studies of projects of which costs may have been especially well controlled. Experiments were thought to be particularly important adjuncts to the study, because there is doubt that theory alone can offer adequate evidence of the effectiveness and acceptability of a new approach to reimbursement. One criterion for support of an experiment is that it yield information that would otherwise be unavailable. Another criterion is that a successful experiment should lend itself to being put into effect for a large class of health facilities.

Several new approaches that are being tested in federal programs or that are expected to be tried soon may yield some very pertinent information.

One of these experiments is intended to test the premise that the establishment of a per diem target rate agreed upon by hospitals and third-party payers will stimulate better management and greater efficiency on the part of hospitals. Starting with the inpatient cost per day for the current calendar year and taking into account a projected percentage of increase or decrease in per diem costs, the participating hospital would propose a target rate and the local Blue Cross Plan would accept or propose a revision in the hospital's reimbursement target rate for the ensuing year. Participating third-party payment agencies would include the Blue Cross Plan, Medicare, and—if feasible—Medicaid. The target rate for a hospital would have to fall within the range established for its hospital group. An incentive payment would be made to hospitals whose audited costs were lower than the target rate by more than one per cent, and the reimbursement to a hospital that exceeded its target rate by more than one per cent would be reduced by a penalty amount. (No penalty would be imposed for a hospital's first year of participation.) A committee representing third-party payers and participating

hospitals would review target rates, final rates of payment, and other issues submitted by the sponsoring organization or a participating hospital. Hospital participation would be voluntary on a year-to-year basis during the life of the three-year experiment.

Built into this experiment is a careful budgeting process on the part of each participating hospital, a translation of the proposed budget into its equivalent per diem cost, and a mechanism for review and approval of the per diem rate. Recording and reporting on work of this nature may be quite valuable.

A second experiment plan would have rate boards participate in establishment of target departmental budgets in each hospital and would provide for evaluation of the details of these budgets by an engineering program that is sophisticated in studies of production standards and comparisons. Consultation also would be provided by a university school of hospital administration.

The purpose of the experiment is to make effective use of uniform budgets, uniform accounting, standardized analyses and reporting, and peer criticism and suggestions to help control hospital costs and improve administration. Department target budgets would be set by rate approval boards composed of hospital administrators, controllers, directors of nursing, and hospital trustees. Nine hospital departments would be included in the program at first, and these nine would be the departments over which hospital administration exercises the greatest degree of control. Later, other departments would be added. Statistics on production rather than cost ratios would be used to determine the relative efficiency of a department and to set the target budget. Payment in this experiment could be made by the Blue Cross Plan, workmen's compensation, Medicare, Medicaid, Title 5, and other welfare programs, thus bringing some of the agencies of state government into the negotiations and agreement.

STANDARDIZED FORMS

A hospital would present departmental budgets for the coming year on standardized budget forms. The rate approval board would set final and binding budgets for each department in each hospital participating in the program. A council of third-party payers and consumers would oversee the operations of each rate approval board from the standpoint of compliance with the experiment guidelines and the quality of its review.

Under the proposal a hospital that is able to surpass the target set for it would receive a reward. A hospital that operates at par would receive the standard Medicare reimbursement.

In both of the foregoing experiments, the setting of the target budget is a critical element. If the target is set too high, the increased payments to hospitals may be very large and may provide rewards where no special achievements have occurred.

GROUP PRACTICE PLAN

The third experiment involves a group practice prepayment plan that presently receives from Medicare a capitation payment based on the reasonable costs for covered services provided to Medicare beneficiaries. In the experiment, the plan seeks (1) to provide a full range of integrated ambulatory and inpatient services by entering into contractual arrangements with hospitals on the basis of per capita reimbursement; (2) to broaden the use of paramedical teams and health workers in order to achieve efficient use of medical manpower, hospitals, and extended care facilities; and (3) to effect economies of administration of this complex system by distributing reimbursement through a single agency.

The implementation of the program will depend on the accomplishments of the plan's medical care planning and administration unit. The functions of this unit will be to assess current patterns of medical care; to develop guidelines for modifying these patterns; to establish relationships with hospitals, extended care facilities, and home health agencies in order to link them to the program; and to evaluate progress in the program. Responsibility for planning, design, definition of standards, and preparation of reports on results of the experiment would be shared with a major school of public health.

This proposal seeks to relate medical and hospital utilization experience and per capita cost rates for enrollees categorized by age, sex, and Medicare and Medicaid benefit status to medical and hospital utilization and cost rates of a matched sample. The community rates would be applied to the enrollees to obtain the "expected" per capita rates for the plan, and the amount of incentive payment would depend in part on the extent to which actual experience is less than the expected rate. Relative changes in plan rates as compared to community rates over the three-year period of the experiment also would be factors in determination of the incentive payment. If the relative increase in plan utilization and

cost experience from year to year is less than the relative change occurring in the general community, the plan would profit.

QUASI-PUBLIC AGENCY

The fourth proposal may not develop into a full-fledged incentive reimbursement experiment, but it will involve many of the characteristics of incentive reimbursement and undoubtedly will provide information on cost reduction techniques and incentives, and it may prove helpful in developing experiments under other sponsorship.

Under the fourth proposal, an existing quasi-public agency presently exercising statewide cost-finding authority would be assigned consultative and educational responsibilities. The agency's work would proceed in four steps: first, review of costs in all of a state's voluntary hospitals and comparison with each other and with hospitals across the United States; second, determination of which hospitals have high costs because of managerial inefficiency; third, suggestion of ways for high-cost hospitals to reduce their costs; and fourth, establishment of maximum third-party payments.

The program will, if successful, be an evolutionary one, gradually growing in scope and effectiveness. It should produce early results that will indicate whether it is feasible for an external organization to identify and help to correct specific items of excessive cost. The program may be able to contribute to improved management practices, as a result of which other economies can be achieved. Also, the program may help develop a broad base of comparative data and the methodology for its use in expanding the initial effort.

OTHER EXPERIMENTS

Several other proposals are being considered. One project proposes a trial of a method of reimbursement for hospital services that would use "productivity standards" for measuring hospital efficiency and provide incentive payments related to these.

Under this project, a "labor performance budget" for each hospital and each cost center in the hospital would be prepared. This budget would cover the anticipated total annual volume of activity for the cost center and establish a labor unit standard for the activity. The budget would set the target for the center. A productivity percentage would be calculated for each hospital on a ratio of actual labor hours used as compared to the hours provided for in the budget. The incentive payment formula would permit incentive payments when the total hospital operations showed a productivity percentage at the end of a budget period that exceeds the average for all hospitals at the beginning of the period.

Two other projects also are of interest, although neither is part of the incentive reimbursement program. Both projects involve provision of physician services to indigent persons under Medicaid auspices. Both programs provide assumption of risk for services furnished to a Medicaid population by a physician-sponsored prepayment plan. The plans include utilization and cost controls by physicians for all beneficiaries.

Under one plan, the physician is held responsible for the total cost of care rendered to his patients, including hospital care. If the average total cost per case exceeds the average for all the plan's physicians by 15 per cent, the payment to the physician is reduced to 15 per cent above the average. The physician has the right to appeal the reduction to the plan's board of trustees. Members of the plan's utilization review committee meet weekly and review every case involving a plan beneficiary in a hospital or extended care facility. If the committee believes that a patient has been hospitalized unnecessarily or is staying longer than usual for the diagnosis reported, the attending physician is contacted. Unless some action is taken to satisfactorily amend the situation, payment is stopped. In addition, a surgeon is required to submit a copy of the pathologist's tissue report for each of his cases. Once a year the board of trustees reviews all of the issue reports and calls upon physicians to discuss any cases where the report does not show that surgery was indicated. Unless satisfied with the physician's explanation, the board may refer the case to the medical society grievance committee or the physician may be charged with the total cost of the case.

The program is financed by funds the state welfare department otherwise would have allocated to the care of individual patients. By focusing the attention of the physician on the total cost of care he provides, the plan attacks the cost problem in a particularly interesting and perhaps more meaningful way than one that focuses on the costs of hospital departments without quality controls.

CALIFORNIA PLAN

The other Medicaid experiment is being conducted by a California medical care foundation. The foundation has contracted with the state to furnish medical services for a fixed sum per month per enrollee. Success in furnishing services for the sum agreed upon will depend in large part on the cost control effectiveness of the claims management and quality control mechanism developed by the foundation. A panel of 20 physicians reviews all claims received by the foundation. Claims requiring special attention are examined by a review committee composed of the entire panel of reviewing physicians. About 25 claims per thousand are questioned to the extent that letters are sent to the claimants and about four claims per thousand are examined by the review committee.

Because Medicaid costs are a critical problem in many states, the progress of the foundation in controlling costs should be followed with considerable interest.

Experiments such as these, of course, not only may be of value in testing certain hypotheses about incentive reimbursement methods, but also may provide bases for determining whether and in what way reasonable costs can be separated from unreasonable ones, how budgets of hospitals can be planned and reviewed, and how utilization review can function more effectively. From such knowledge the development of better health care systems can proceed.

Appendix A

Supplemental Report

Council of Medical Service, September 14, 1969

To the House of Delegates:

Resolution 68–12 (Availability of Medical Care)

In adopting Resolution 68–12, the 1968 House of Delegates of the Pennsylvania Medical Society recommended that a program be developed to assure high quality medical care for all citizens of Pennsylvania.

This Resolution (Appendix A) was referred to the Council on Medical Service for implementation. As indicated in the Council's Annual Report to the House, it was not clear whether the intent was re-state a basic objective of the Society or whether its sponsors had a specific program in mind to achieve this objective. As a result of correspondence with the author of the Resolution, the Council learned this his intent was to have the Pennsylvania Medical Society sponsor the development of medical centers in poor urban areas to be financed through voluntary contributions, Pennsycare payments, OEO funds, and possibly through the donation of monies via the members of the Pennsylvania Medical Society. In addition, it was suggested that medical instruments, drugs, and other medical supplies might be obtained through donations from drug companies.

It is the feeling of the Council, that from a practical point of view, the Pennsylvania Medical Society and its component county medical societies cannot undertake the development of medical centers of various types, but can give encouragement and support in various ways to new projects such as, for example, in the past year, a multiphasic screening program in Philadelphia, a diagnostic virus and mycoplasma laboratory in Philadelphia, Gateway Medical Center in Pittsburgh, and a medical student preceptorship program under Appalachia. Individual physicians and county medical societies should be encouraged to exert leadership.

However, the Council agreed that the Pennsylvania Medical Society should continue to call attention to factors which appear to interfere with the availability and delivery of quality medical care and should participate in efforts to improve problems in the financing and delivery of health care. Because of the influence of several factors over the past three or four years there has been a significant increase in demand for medical services which has further accented the inequity in the distribution of health care resources at a time when the government and the public have expressed widespread concern about this apparent lack of equity and the cost of health care continues to rise. Of particular concern is the assumption that many citizens of Pennsylvania with inadequite income, for a variety of reasons, either do not obtain needed medical care at all or obtain it under conditions are are below the standard of care utilized by the general

population. An additional concern are those who could afford to pay for medical and hospital care on a prepayment or insurance basis, but who either elect not to do so or are not eligible for effective coverage. Such situations create serious personal financial problems for the patient's family and when people in this category become seriously ill, the public must share the financial burden, since those who have prepayment or insurance plans must pay both higher premiums and higher taxes to subsidize the uninsured.

The Council believes that Resolution 68-12 was designed to aid the former group in meeting their health care needs as well as upgrading the care available to those able to afford it, and we suggest that the Pennsylvania Medical Society pursue the following alternatives as a means of achieving the basic objective of the Resolution.

The Pennsylvania Medical Society should:

1. Reaffirm its desire to support projects whose objectives are to improve the financing and delivery of health care organized in such a way as to develop or strengthen a first class system of health care which will embrace the principles of medical ethics of the American Medical Association.

2. Support a mechanism or system for financing health care that does not limit or restrict the methods of providing health services or interfere with the choice of providers in order to preserve the desired freedom of choice for both patients and physicians.

3. Urge that, to the extent possible, the system or plan should utilize existing financial mechanisms—Blue Shield, Blue Cross, insurance companies, group practice plans, and other *voluntary* programs.

4. Urge payment for physicians' services, regardless of where they are provided, to be determined by application of the usual, customary, and reasonable fee concept.

5. Support the development of an adequate Pennsycare Program, in accordance with past action of the Pennsylvania Medical Society, appropriately financed with a greater share of federal funds for all covered services as an interim step toward organizing a better system of health care.

6. Support the concept of allowing Social Security beneficiaries a choice of fiscal intermediaries giving them a greater flexibility to experiment in the design of benefits to improve service, benefits, and conserve health manpower to avoid further diversion of health care personnel to administrative work, which both inflates the unit cost of service and diminishes the manpower available for patient care.

7. Support the graduated income tax credit program proposed by the American Medical Association to strengthen the voluntary health insurance industry and to reduce the need for governmental health programs.

8. Support legislation at both the state and federal levels that would make available to all employed persons and their dependents a voluntary non-governmental prepayment or insurance health care plan of maximum flexibility but with benefits no less than the minimal Blue Cross-Blue Shield Programs.

9. Support legislation that would provide greater incentives for medical schools to increase enrollment.

The Council fully realizes that these nine (9) recommendations must be considered long-range objectives, but their implementation in the end may very well achieve the goal of developing and financing programs to assure high quality care for all citizens of Pennsylvania. Moreover, there has been much discussion regarding universal compulsory coverage and such a program should render obsolete the need for national governmental compulsory health insurance by assuring a comprehensive health plan for everyone.

Based on these guidelines, this system of financing offers a number of advantages:

1. A minimum burden is placed on the federal government since its further financial commitment would involve only the subsidization of premiums for those individuals and families unable to afford the premium for coverage.

2. It would preserve a large role for decentralized decision making which is important for the stimulation of individual effort and for the opportunity to experiment with alternative approaches.

3. The system preserves the desired freedom of choice for both patients and physicians.

4. The system permits the patient to purchase more than the basic coverage which is consistent with the general free approach to consumer spending and this would likely encourage the upward movement of quality which tends to suffer when there is an attempt to freeze everyone into a single standard.

(Resolution 68–12: Availability of Medical Care; As adopted by House of Delegates of Pennsylvania Medical Society, September 28, 1968)

Whereas, the availability of medical care may be unequal in all areas of Pennsylvania; and

Whereas, organized medicine has taken no major action in assuring the availability of good quality medical care to all Pennsylvania citizens, and

Whereas, Government agencies are planning government or institution-based programs to assure good medical care to all citizens; Now, therefore, be it

Resolved, That the Pennsylvania Medical Society authorize and direct the appropriate Council of the Society to formulate a plan whereby organized medicine may assure the availability of quality-medical care for all citizens of Pennsylvania.

PENNSYLVANIA MEDICAL SOCIETY—BLUE CROSS OF WESTERN PENNSYLVANIA

REGIONAL STEERING COMMITTEE

The Tenth Councilor District Medical Care Coordinating Committee proposed a reorganization of the jointly sponsored Review Program of the Tenth Councilor District and Blue Cross which was presented by the Council on Medical Service at the January 8, 1969 meeting of the PMS Board of Trustees and subsequently approved on a pilot basis.

I. The Western Pennsylvania PMS—Blue Cross Regional Steering Committee shall be responsible for coordinating the activities of the Pennsylvania Medical Care Program within that area serviced by Blue Cross of Western Pennsylvania and shall provide advice on matters of policy and procedure to both Blue Cross and the Pennsylvania Medical Society.

II. The Regional Steering Committee shall be responsible for establishing and supervising whatever subcommittees it deems necessary, such as the following.
   A. Blue Cross Medical Advisory Committee
   B. PMS—Blue Cross Extended Care Facility Review
   C. Blue Cross Medicare Advisory Committee

III. The Regional Steering Committee shall be responsible for the appointment of the various chairmen to serve in a review capacity.

IV. The various components of the overall review mechanism shall prepare at least an annual report for Blue Cross and the Pennsylvania Medical Society with respect to pertinent facts and problems of its particular operation.

V. The joint type of review activity for inspection and certification of Utilization Committees of hospitals and extended care facilities previously agreed to by PMS and Blue Cross of Western Pennsylvania would come under the purview of this Committee.

VI. The Regional Steering Committee shall be responsible for working out a table of organization jointly acceptable to PMS and Blue Cross with respect to the proliferating areas of joint responsibility with Medicare, Medicaid, and other programs.

VII. The Regional Steering Committee will report directly and be responsible to the Council on Medical Service and Blue Cross of Western Pennsylvania.

VIII. Minutes of each meeting of the Regional Steering Committee will be submitted for information to the Council, each Trustee involved, each County Medical Society within the region, and Blue Cross of Western Pennsylvania.

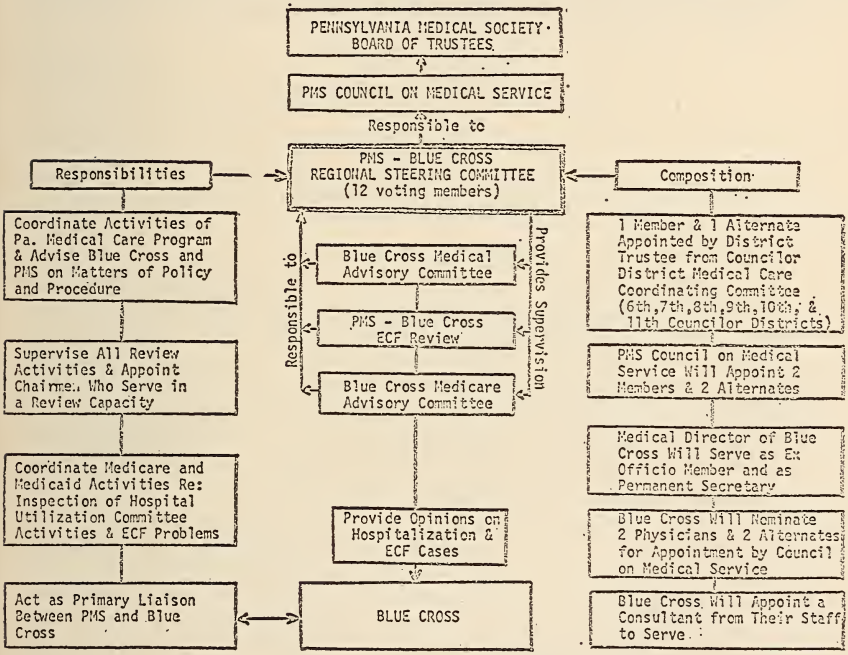
IX. The attached organizational chart is intended to outline the areas of responsibility of the Regional Steering Committee.

X. The Reginal Steering Committee shall be composed as follows:
   A. Twelve members with one vote each.
   B. In each Councilor District involved, the Trustee and Councilor will appoint a member and an alternate to the Regional Steering Committee from his District's Medical Care Coordinating Committee. (The 8th, 9th, 10th, and 11th Councilor Districts will be totally involved and portions of the 6th and 7th Districts will be included.) (Six voting members)

C. The Pennsylvania Medical Society's Council on Medical Service will appoint two members and two alternates to serve on the Regional Steering Committee. (Two voting members)
D. Blue Cross of Western Pennsylvania will nominate two physicians for at-large appointment to the Regional Steering Committee by the Council on Medical Service. Blue Cross will also be asked to nominate two physicians as alternates. (Two voting members)
E. The Medical Director of Blue Cross will serve on the Regional Steering Committee as an ex officio member, with vote. (One voting member)
F. Blue Cross will appoint a consultant and alternate to the Regional Steering Committee from their staff to serve, with vote. (One voting member)
G. Other staff members of Blue Cross and PMS will attend meetings without vote to assist the Committee in handling its business.
H. The Regional Steering Committee shall elect its own chairman and vice chairman and the Medical Director of Blue Cross will serve as permanent secretary.

ORGANIZATIONAL CHART

APPENDIX B



PENNSYLVANIA MEDICAL SOCIETY

REVIEW PROGRAM FOR PHYSICIAN SERVICES

The following guidelines were recommended by the Council on Medical Service and approved by the Board of Trustees on January 8, 1969 to expand the Society's capacity to handle disputed fee cases and utilization problems presented by Pennsylvania Blue Shield (including cases involving Programs administered by Blue Shield), commercial insurance carriers, and other third parties in conformity with the provisions of the Pennsylvania Medical Care Program.

I. The Vice President of Medical Affairs of Blue Shield will have the choice of using one or both of the following alternatives in the initial handling of a questionable claim:
   A. Refer a claim to a member of the Blue Shield Medical Advisory System for suggestions when the claim requires advice of a technical nature.

B. Refer a claim to the Utilization Committee of a hospital for its recommendtion when the propriety or necessity of a physician's service rendered during hospiitalization requires advice.[1]

II. After receiving advice from a member of the Blue Shield Medical Advisory System and/or a Hospital Utilization Committee, the Vice President of Medical Affairs can choose one of three alternatives:

A. Recommend payment of claim as originally submitted.

B. Take arbitrary direct action to settle the claim, informing the physician of his right to appeal to a Councilor District Review Committee of the Pennsylvania Medical Society.

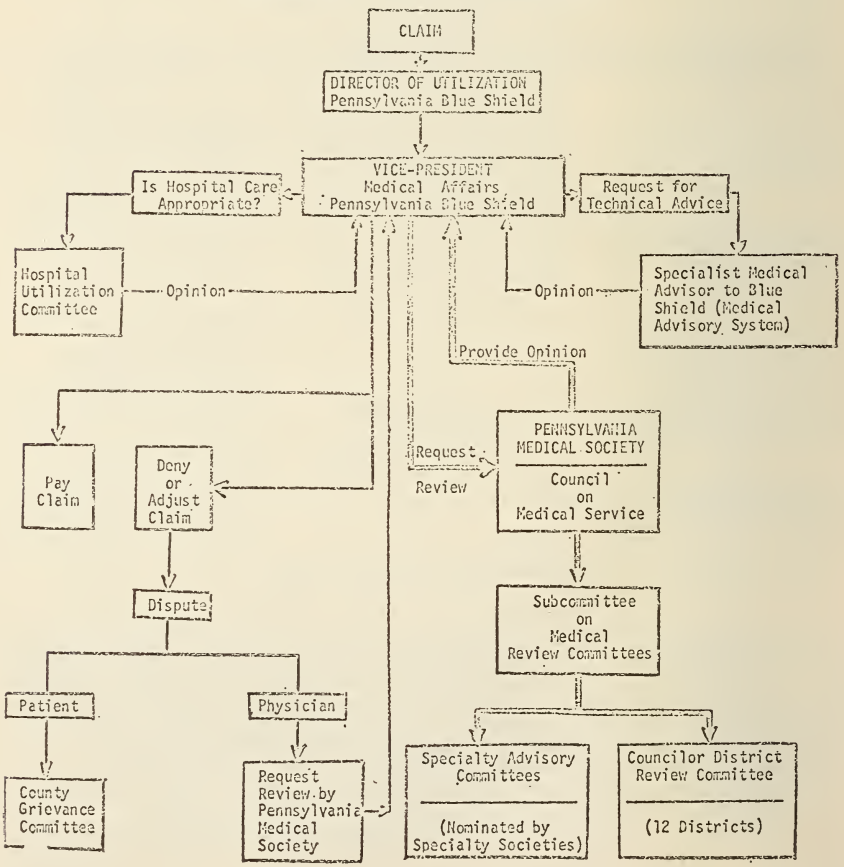
C. Refer the claim directly, before taking any action, to the Pennsylvania Medical Society requesting the claim be referred, depending upon the nature of the claim, either to a Councilor District Review Committee or to the appropriate Specialty Advisory Committee for an opinion. (This procedure will be utilized by the Pennsylvania Medical Society in handling any cases presented for review by commercial insurance carriers and other third parties.)

III. Any request for review may be referred to the Council's Subcommittee on Insurance Review for an opinion, if such advice is not provided after the above mentioned alternatives have been thoroughly exhausted.

IV. Any physician shall have the right to appeal any decision reached under the foregoing to the appropriate Councilor District Review Committee.

PREVAILING FEE PROGRAM

PROCEDURE FOR HANDLING QUESTIONABLE CLAIMS



[1] A County Medical Society may form a special committee to perform this function.

Dr. MARSHALL. If you have questions, this blue booklet may be the easiest way to understand what we are talking about with hospitalization reviews; you will notice how this enables us to do this pattern review. First page shows how these abstracts are compiled in the medical record room.

The second page demonstrates how the computer result comes out, the listing monthly of such things as diagnosis, analysis by service. Semiannually, we have a diagnoses index operation, physician listing, surgeon listing that enables us to do comparative studies somewhat similar to those described by the foundations.

Then we have statistical comparisons on page 3 which show how your hospital compares with others, how the length of stays are moving downward as compared to other hospitals.

Then with respect to your hospital profile on page 4 it demonstrates how, for instance, the first hospital is rather low with regard to uncomplicated diabetes. Acute coronaries it is higher. Pneumonia is relatively low; it demonstrates by either the black or the corrugated line whether the length of stay in the particular hospital is increasing or decreasing.

We provide each hospital with individual case review sheets which are shown on page 5.

And then on page 6 it shows somewhat similar to the foundation diagnostic criteria, in this case for cholecystitis and cholelithiasis.

Then we have case review analyses which can be performed for any of the hospitals who desire them with regard to what might be special problems that could be revealed, for example, by the hospital profile shown on page 4.

The research and development concerns special problems and, by a contract with U.S. Public Health Service, HUP has a special study with respect to extended care review and you have copies for the staff of material which was developed for them showing how simply a review can be done. In addition, the appendixes here show the Blue Shield mechanism has similarities to the foundation programs. The attachment shows how Blue Shield handles a special claim. It is referred to the medical director. He may refer it to the medical adviser he hires to be able to give him advice as to a special problem. There are a few occasions when it can't be worked out and when it can't it comes to the Pennsylvania Medical Society.

We have several options. We have 17 review committees for 17 specialties in Pennsylvania. We can refer to them. We can refer, to council or district, regional reviews for their opinion. Currently we have about 24 physicians under review. Blue Shield has previously presented testimony to you and I would imagine they have a group of 150 physicians under review for reasons somewhat similar to those described by the San Joaquin Foundation.

The physicians who have unusual profiles of this nature are subject to special surveillance. On the other hand the 95 percent or so of the physicians who do not have special problems do not have to have pre-

authorization, for example, for payment. It is only where there is a problem that this is the case.

Senator ANDERSON. This is a very good job.

Senator WILLIAMS. Doctor, on the first page of your statement you referred to a series of seminars on medicare which your society sponsored for doctors in 1966 to familiarize them with the program. Has your society sponsored any further seminars since that time?

Dr. MARSHALL. No, sir. The Blue Shield has, however, sponsored seminars in which they described the operation, principally of a technical nature, to help people who are working in offices to fill out forms and explain what the benefits are.

Senator WILLIAMS. How many other State medical societies have hospital utilization review programs similar to yours?

Dr. MARSHALL. I have no idea, sir.

Senator WILLIAMS. You have no idea. To what extent would you estimate that your own hospital utilization project has reduced or prevented unnecessary or overutilization of hospital care?

Dr. MARSHALL. Well, that is difficult to measure. I did submit statistics to you indicating 25 diagnostic categories, 1964 through 1968, and you will notice that during this period of time there is variation from year to year, but the last page of this shows that these remain approximately level during this period of time. I understand there has been a 2-percent increase nationally.

The Blue Cross of Western Pennsylvania, in a recently increased rate filing, has used a figure of possibly 1 percent. So I think we have achieved a leveling off.

I think you can imagine the problem if all of a sudden there were many empty beds in Pennsylvania. In a large area like this, you cannot change things too quickly since the empty beds would create a problem, and, as long as they were maintained and staffed, someone would be required to pay for them. If there is a large population base, I am sure utilization for a small percentage could be reduced without producing repercussions, but when reduction of utilization is on a larger basis, it is necessary to coordinate those changes with hospital planning and State government inspection and licensure activities in this field. I am looking forward to progress in the spirit understand and cooperate with these changes. Certainly a more aggressive program of reduction in utilization can be accomplished more smoothly when there is an expanding population base and increasing numbers of physicians as compared to a situation where the population base and the physician supply are static or dwindling.

To date, I believe we have achieved a modicum of cooperation between hospital-utilization and planning activities as well as the State's activities in ths field. I am looking forward to progress in the spirit of mutual cooperation. Certainly our activities, with respect to potential fraud on the medicare and medicaid programs, have been cooperative, for such cooperation is appropriate.

Senator WILLIAMS. That is all.

Senator ANDERSON. Thank you very very much for your comments.

Dr. MARSHALL. Thank you.

Senator ANDERSON. We will adjourn until 10 o'clock tomorrow morning.

STAFF. We did have some staff questions for the record for the San Joaquin and Sacramento Foundations.

Your two foundations are sponsored by the country medical society, is that correct?

Dr. HARRINGTON. Yes.

STAFF. Has your State medical association encouraged and cooperated fully with you in your innovative and obviously effective effort to control the high costs of health care?

Dr. HARRINGTON. I would say in recent years our State association has worked with us and been quite cooperative. In earlier years, when they didn't understand the program, they were hesitant to lend their seal of approval but at the present time they meet with us at the county level. They come to our federation meetings and our CMA—county medical association—is helpful with us.

STAFF. Is the situation the same in Sacramento?

Dr. BRAMHAM. This is a new program and we feel they are having some questions about it in some areas. The CMA has called a conference for the next month to find out more about it. Also, we have announced a statewide workshop July 15 devoted to the concept and mechanics of CHAP for all interested parties in California.

STAFF. Particularly in Sacramento, and to some extent in San Joaquin, exactly what kind of overutilization of extended care have you found?

Dr. HARRINGTON. I thought you were talking about their hospital program.

STAFF. Yes, sir.

Dr. BRAMHAM. In the hospital programs there are many kinds of overutilization. Usually it is just staying too long or longer than is medically necessary. There are some patients who are being admitted to the hospital, however, who don't belong in the hospital, and this is a difficult thing to measure. It is like how many accidents you prevent by an accident prevention program.

STAFF. But have you found specific cases where, for example, when your program started, you found that overutilization was occurring?

Dr. BRAMHAM. Yes; I can give you some examples. One is a person who, just before CHAP began, was admitted to the hospital for carcinoma of the lung, which would appear to be a good, legitimate diagnosis. However, when the nurse reviewed the charts, when CHAP cinoma of the lung, which would appear to be a good legitimate before. The only reason the man was in the hospital was because his health insurance before medicaid had not provided outpatient diagnostic services. He was in for a diagnostic workup to see if there was any recurrence of his cancer. All of his studies could have been done,

and generally are, as an outpatient. When we pointed this out to the doctor, he was agreeable to discharging him for studies as an outpatient. Any plan with CHAP should have realistic outpatient diagnostic benefits.

Staff. Are there any other examples you have found?

Dr. Bramham. We have had two amputee problems that were good examples. One doctor requested a month's extension on one of them for the stump to shrink better to fit an assistive device. This obviously did not require acute hospitalization, and the doctor agreed to it and discharged the patient.

Another one was in the hospital for about a month and a half while his doctor was trying to develop a new type of prosthesis. This also could have been done on an outpatient basis. This case we found at the end of the month and a half rather than at the beginning, because this period had elapsed before the CHAP program became effective.

Dr. Harrington. He has another case I would like to have him describe to you. The point is here that perfectly honest physicians because they are not grounded in the social aspects of medicine, may sometimes keep patients in too long, or by the habits of their practice they may keep people in longer than other physicans doing the same kind of work. Sacramento has a good case in point, that of an ophthalmologist.

Dr. Bramham. One of our good ophthalmologists has always kept his patients in the hospital following cataract removal for 10 or 12 days. Our nurse coordinator called our attention to the first such case of his to come under CHAP review.

The PAS 50th percentile says 7 days and, in California, cataract surgery usually averages 6 or 5 in-hospital days. We checked with a few of the other eye doctors, and they agreed. Then we talked with this doctor, and he agreed that maybe it was time for him to adjust his practice to more modern standards. He is now discharging his cataracts usually on the 6th day. This is a spillover benefit of CHAP because it applies to his nonmedicaid patients as well.

Dr. Harrington. There is another aspect of this. They have not yet gotten into extended care facilities which they are going to. We have come up with a problem. Dr. John Morozumi, who has been our consultant with the welfare department and has been in charge of handling our extended care facilities and long-term care, finds that when a doctor like myself, a gynecologist, again not too familiar with nursing homes because I don't use them very often, needs to discharge a cancer patient that needs to go to a nursing home, by the time I make up my mind to do this, then it takes another 2 weeks to get her into a nursing home. So RMP is funding a program in San Joaquin County, a program of coordinated discharging plan so that all of these people, who have the kind of illnesses or conditions that will require nursing home or long-term-care facilities are put on the roster and are observed so that the discharge, the minute they are able to be discharged, can be effected. We are just getting into this and are hiring nurses. I think this is an area that will make a lot of salvage. We will get into the acute hospital problem as the two dovetail very well.

Staff. Do either of the foundations undertake review of a request to hospitalize patients for surgery?

Dr. BRAMHAM. Nonemergency surgery?

STAFF. Yes.

Dr. BRAMHAM. Yes. These are all reviewed prior to admission to the hospital if it is elective surgery.

STAFF. Have you rejected any proposed surgery because, it was unnecessary or for other reasons?

Dr. BRAMHAM. Yes. There have been some. One was a doctor who wanted to admit a woman who had intermittent bleeding. The reviewer felt this was not necessary. The attending doctor objected, and we had a consultant see the patient.

The problem was she was taking birth-control pills on an intermittent basis, and this produced spotty bleeding. She did not need to be in the hospital or have a D-and-C procedure; she needed to follow the correct use of birth-control pills if she was going to take them.

This was her only problem; she did not need surgery.

STAFF. Did you have any of those cases, Dr. Harrington?

Dr. HARRINGTON. Not that particular problem. Actually, we do not do preadmissions at the present time. We have used a few physicians that we required consultations on. But that is about it at the present time.

I think the program that they are sponsoring is something that has a great deal to commend it, and I think we should move into it rapidly.

STAFF. Both organizations, particularly Sacramento, provide peer review with respect to the total care provided a patient.

Do you find such comprehensive review necessary to an effective program?

Dr. HARRINGTON. Let us change what you said. What you said was that we both—that they utilized peer review for everything. Something has got to be made clear. We use peer review for everything. However, we use after-the-fact review for hospital, and this is not good enough. In other words, everybody is using the words "peer review" so glibly that they do not bear down on the fact that it has to be before payment, not after payment, and that is what they are doing.

STAFF. Are you satisfied that peer review has to encompass the totality of care?

Dr. HARRINGTON. Yes, sir.

STAFF. Why?

Dr. HARRINGTON. If you do not, it is possible—I cannot give you any examples at the moment, but it is possible—for a physician to keep patients in the hospital x number of days and bill for those visits two times that. In other words, until you collate the two and observe them, you have no way of knowing what is going on.

STAFF. With respect to your requirement of recertification in Sacramento for length of stay beyond the 50th percentile, what proportion of physicians' requests for an extension of hospital stay beyond that initial screening point have you turned down?

Dr. BRAMHAM. We do not have a firm figure for that as yet. There have been some, but not many. Most of the doctors, when they know that this initial period is up and the case no longer has a medically necessary reason for additional care, do not apply for additional hospital stay. It is the attending doctor's joint responsibility with the hospital to apply for extension of care; if it is medically necessary he is going to apply, of course. So most requests, to date, are bona fide requests. There are a few that we turn down.

STAFF. Do you find that using the length-of-stay criteria, by diagnosis and age groups, is much more satisfactory and appropriate as a way of reviewing care rather than the arbitrary 7-day, 13-day, 21-day criteria which are presently used in the medicare program?

Dr. BRAMHAM. That is right. Establishing lengths of stay by an arbitrary number of days is not the way to do this kind of certification and review.

In California, medicaid usually reviews cases on the 8th day, and under medicare cases have been reviewed on about the 13th day.

Of the 25 most frequent causes of hospitalization from data from California hospitals, there are only two conditions among these 25 which exceed 8 days. These are displacement of interverterbral disc, for which the average hospitalization is 10 days and still under the medicare limit. The only one that exceeds that is 17 days for acute coronary occlusion.

So if you start reviewing cases on the 13th day—or even the 8th day—you have let too much time go by.

In addition to this, I might say, regarding coronary occlusion, there are a number of patients who are admitted with this diagnosis, who do not really have it. They may have a hangover, or gastritis, or one of numerous other causes of pain and not a coronary at all. This is why it is important that the nurse coordinator be in the hospital and report on that patient as to whether he indeed has a coronary.

STAFF. What you are saying is that even a 4-day stay may be too long?

Dr. BRAMHAM. Yes, a 4-day stay may be too long for certain problems.

Dr. HARRINGTON. Can I get into this a minute because this is going to take you a while to develop from county to county? However, an administration device whereby each hospital develops their own length of stay for each procedure, which is what we are influenced by in our area, by sending overstays back to the utilization committees of those hospitals. Our people now stamp on the front page, A, B, and C cannot stay more than 2 days; a tonsillectomy cannot stay more than 2 days.

If they stay longer than that they have to recertify at that time and change the diagnosis and say why. This is something that could be started soon because it requires only simple administration.

It is not the total answer, but by doing this the days of stay that we have reported on, which have been improved in our county over the test county in hospitals.

STAFF. With respect to Sacramento's prior certification program, I believe you mentioned something like 1 percent of the physician requests for hospitalization have been turned down. We had heard from another source that it was as much as 30 percent. Is that correct?

Dr. BRAMHAM. I have no accurate figure. I am sure it is not 30 percent.

Mr. DOCHTERMAN. I believe that reference is in the context of 30 percent of hospitalizations, those diagnostic in nature, are not being made because of the program and its requirement of preadmission authorization and case review.

STAFF. You mean the deterrent effect as well as the actual?

Mr. Dochterman. The Sacramento experience would indicate there is no question about it.

There is one other aspect of this program that should be clarified, and that is that CHAP throws no one out of a hospital. It is explained to the physician and the patient and to the hospital that the number of certified days is simply the extent of the financial liability of the health plan. If patients want to make plans for longer stay, it is up to them and the hospital to make such arrangements.

There is pending another aspect of CHAP since the State of California has asked that this program be extended to extended care facilities under the medicaid program in California.

Frankly, this is a rather awesome job in our county with 55 such facilities. We are just "getting our feet wet" with 12 hospitals under CHAP, but we do think that it has value eventually in the ECF area.

Staff. In San Joaquin or in Sacramento, did you find hospitals which insisted on duplicating X-ray or diagnostic procedures which your physicians had completed prior to the patient's admission to the hospital, and if so what did you do about it?

Dr. Bramham. We have one small hospital that does this, and so every doctor on the staff is on total review.

We review every medicaid claim from that hospital, including those of its staff. We are comparing what the doctor or his colleagues are doing and billing as an outpatient service, with what is being done by these same doctors, one of who owns the hospital, as an inpatient service. Frequently, whole batteries of tests are repeated a day or two later and billed then as in-hospital services.

Staff. Is that a problem peculiar to proprietary institutions or doesn't it also exist in the nonprofit community institutions as well?

Dr. Harrington. There are three reasons, I would say, and one of them is good medical care. That is an important reason, No. 1. Another is economic, such as proprietary hospitals.

The third is medico-legal. For instance, under the joint commission, certain laboratory work is necessary for admission. A hospital could not possibly give a transfusion without having done the cross-matching and the typing themselves. So here is a duplication that could occur. Actually we have solved our problems much the same way as Sacramento has.

We have a couple of proprietary hospitals that require X-rays and other such preadmission tests, which we just do no pay them.

Staff. To what extent have your programs educated your physician members concerning norms of care and treatment; and do you feel that such education is a valuable part of your reviewing program?

Dr. Bramham. Hopefully, it is a tremendous spinoff that will occur during the next year or two. Our doctors are pretty much aware of this program because we had developed a sound commercial CHAP program involving about 2,000 persons before taking on the Government medicaid program. They did have some knowledge about it.

So even by inserting a large number of patients under CHAP—we have 70,000 medicaid patients in Sacramento County—there has been a great improvement in physician cooperation and education.

I think that this plan offers a lot of side benefits that should result in less hospitalization in many other programs.

Dr. HARRINGTON. Could I answer that, too, from a different aspect? Actually our county runs three postgraduate study courses, you might say. One is the oldest one in California, which is run by the medical society and brings in speakers.

The second postgraduate study course is our reviewing physicians who come in and review on a daily basis, and their conversations in the surgical dressing rooms and other areas do spill out into the community.

The third, and probably the most important, is our review committee. We found in the past, for instance, that a physician or group of physicians that did not handle any antibiotic therapy well or did not handle Pap smears or some other modality. We would set up a course by a professor from Stanford, say, a postgraduate study course, or at a staff hospital meeting, and a look around the room showed that the physicians who needed the lecture were not there.

We, therefore, bring them into our review committee and give them the same lecture before we pay any of their claims. This, we think, is a pretty good kind of requirement, the membership at this study group.

Dr. BABICH. We also found that, by assuming the fiscal intermediary's duties through our regional claims review office, we are actually in the business of doing this for Blue Shield, and for the period of time we have been doing this has educated our doctors to this point very much.

The hospitals are thoroughly delighted with this program because, in effect, this guarantees their payment for the stated days of certification, and then the other modalities that the other gentleman just expressed are one way of education.

In our particular area, the program has worked so smoothly we think something may be wrong.

Seriously, one other point I would like to make, and that is—and I will get back to peer review, if I may, sir—we feel that peer review means local peer review. In the past we had so-called peer review by State of California-hired doctors who were distant and nonpracticing physicians, and the State program did not work well. Everybody was dissatisfied and unhappy with it. We feel that Long Beach doctors' practice patterns may be quite different from those of doctors in Sacramento. So when you talk about peer review it should be total practice review of and by practicing physicians in their own local community. Pediatrician "peer reviewing" pediatrician, et cetera. This is our concept of peer review.

In other words, there is no single master plan of peer review that I can see being applied to the whole United States or even any State.

STAFF. Assuming that other county societies and similar groups had the same kind of commitment and dedication you people have, is that what you are saying?

Dr. BABICH. Well, I think most doctors are reasonable, and, when they understand the problem and their role in the program, they will cooperate; they are no different from anybody else.

When any people do not understand something they immediately are frightened by it or react negatively to it.

Our program at first glance is somewhat awesome. But after spending approximately an hour or so studying it, it is a very simple concept. It is nothing more than an extension of long-existing medical

peer reviews, but you have to have local, dedicated, and practicing doctors to do the work.

Mr. Dochterman. May I please make one reference to a point Dr. Bramham made earlier? He was talking about the several Government funding mechanisms and intermediaries that can be available to one patient, and how this can be extremely confusing to the provider and the recipient. He did mention that one of these funding agencies is the county. There seems to be a tendency for some counties to lay off onto the Federal or State funded programs what is county responsibility.

When we first got into this program, we found a large number of children who were not ill and should have been in a county receiving home, but were kept in a $72-a-day hospital facility because they were from broken homes of medicaid families. Otherwise, if they were not in a hospital under medicaid funding, the county would be responsible for their full care in a home. This is just another avenue that CHAP has opened up.

Dr. Babich. One other point I would like to make is that irrespective of what plan this Senate committee decides it will recommend, or what State or public programs or private programs may evolve, the CHAP concept will suit any of them, even those on the drawing boards or not yet thought of.

In other areas, we find that CHAP is spilling over into the doctors' private practice. We are now discovering that instead of a shortage of beds, beds are opening up. We feel very definitely in the future we are going to have to redesign our thinking when it comes to future construction needs because we are utilizing our beds much more efficiently. We feel that this is a little bit of dessert from CHAP that the committee should be aware of.

Staff. Doctor, do you feel that in order for the CHAP approach to function properly in other areas you need financial incentives or can it also operate on a professional basis without underwriting?

Dr. Babich. It could occur either way.

Staff. Either way.

Dr. Harrington. Wait a minute. Except you have to have one area, you have to have responsibility, you have to have the ability to say we precertify before the payment will be made.

Staff. The authority and responsibility.

Dr. Harrington. Correct.

Staff. Do your organizations have consultants, to whom you refer questions relating to certain specialists, or to the prescribing of drugs, physical therapy, and such?

Dr. Harrington. Yes. Particularly in the medicaid program, which is so comprehensive, we have the executive committee of the Pharmacy Society that sits as our review committee. We have a general practitioner who is also a pharmacist who heads up our pharmacy committee.

Those questionable claims relating to pharmacy that are of poor utilization because of the physicians are handled by the physicians committee. Those that are poor utilization because of pharmacy problems are handled by the pharmacy people.

As far as within the profession of medicine is concerned, we have what we call peer justification whereby, if the review committee comes

up with a problem that affects ophthalmologists or obstetricians, or whatever, it then goes to a group of those peers to get what their thoughts are.

STAFF. Fine.

In the discussion which the staff has been having with various people, that was one of the concerns expressed.

Dr. HARRINGTON. However, in view of the fact that we only produce 10 percent of the costs, we are responsible for 80 percent of the referrals; therefore, the prime thrust in all reviews has to be the medical profession because we are responsible for putting people into hospitals and writing the orders in the hospitals.

Therefore, the hospital people themselves would be in a difficult situation to try to carry on a peer review program because, in effect, they are reviewing the peer activities of the physicians.

Now, when you get down to administrative charges in hospitals and administrative costs, there you need the peer review judgments of the hospital people.

STAFF. Have you had any encounter with the type of physician who claims he has no peer?

Dr. HARRINGTON. Yes, we do, and after we treat them long enough they go to Los Angeles. [Laughter.]

Seriously, this has happened. We have one now that we have a stack of some $11,000 worth of claims on. We have turned the physician over to the board of medical examiners, who cannot apparently get their hands on him.

He has got his hands on too many other people. He is in a State psychiatric hospital at the present time. Until we got this thing squared away we had real difficulties. He is a true psychopath.

STAFF. We have had experience with physicians who are subspecialists in an area, who claimed their work is so specialized that there is no one in their community, or even in their State, who is capable of exercising a peer review function with respect to the services they perform.

Dr. HARRINGTON. We have had this problem, and, in this particular instance, we wrote to the professors, I think it was 12 universities, scattered throughout the country, asking what the practice in their medical school was on this particular point, and then we reacted according to it.

STAFF. Thank you.

Dr. BRAMHAM. Yes, we have a problem that is a little different. We have all of the problems that Dr. Harrington has, but we also have problems of a medical school. Sometimes they have specialists which do not exist in the community practice. I recently had some conversations and letters with the medical school and its doctors in physical medicine. There is no doctor in physical medicine in private practice.

They are being reviewed by orthopedists, and when the case needs someone else, then the orthopedist calls in a pediatrician or internist or some other appropriate person. We just have to do the closest that we can in some of these areas, but it is not that difficult.

STAFF. Doctor, the point there was whether or not it was feasible to have an umbrella organization, a single review group with overall responsibility, which had the capacity to arrange for these other variables.

Dr. HARRINGTON. Yes, it is.

Dr. Bramham opened up another can of worms, I think, that you should be aware of.

We have had some experience in this both in medicaid and in our commercial program.

Our people will on occasion go down to the University of California, which is a fine place because I graduated from this, so I am prejudiced. However, they would go there, and there are three kinds of charges that we will get from the University of California. First, they were just lumped into one thing, and then we went down and talked to them, and we said we did not feel that either the ILWU Trust Fund or the Automotive Car Dealers Association Trust Fund should be charged for those services, laboratory, X-ray, professional or whatever, or extension of hospital stay which is due to teaching services, or to research.

So, at the present time, the University of California bills us for our people who go there. I do not think they bill anybody else there for that, in that way. They bill us for actual therapy, and then delete those things that are teaching or administrative because we do not feel at the present time the tax base should be used for these purposes.

Dr. BRAMHAM. We feel this is very important. The medical school is training medical students and interns and residents, and medical economics is an important aspect of their training: how long should a patient be kept in a hospital, how many diagnostics procedures should be ordered, and should they be hospitalized for them.

I recently denied an admission of a medicaid patient where the intern wanted to keep the patient in overnight for an examination for pinworms. This can be very adequately done as an outpatient and does not require $72-a-day hospitalization. That hospitalization was denied, and the intern has learned a lesson, I think.

STAFF. Do you now, or will you in the future, require hospitals to set up a patient's record and complete diagnostic tests to the extent feasible prior to admission?

Dr. BRAMHAM. We are asking them to do this now with CHAP. It is part of medical necessity for hospitalization. If a procedure can be done as an outpatient, it should be done as an outpatient.

The only time that we will authorize a hospital workup for diagnosis is when the patient is so ill that he requires hospitalization or the tests are of such a nature that they require hospital care, such as a myelogram or certain other studies which are uniformly done in the hospital.

STAFF. Do you believe that your system of routinely getting individual patient and physician profiles is feasible, given present computer capacity and techniques, in large urban areas?

Dr. Harrington. We will tell you more about that in 2 years. At the present time it is, it so happens, that Dr. Bramham and myself are on the computer committee working with four insurance groups in California that have a contract with the State of California, a $6 million contract, for the purpose of programing medicaid for ongoing review.

In discussion with both people in HEW and with people in the computer companies, this is a completely feasible thing.

It is obvious that the kind of work that both Sacramento and San Joaquin and other functions are doing is really a manual review with electronic data processing backup. If you are going to get into New York or Philadelphia you are going to need electronic data processing with backup review. It is feasible and possible, and I hope you people do not get into a national health insurance until we have gotten this thing straightened out.

Staff. Isn't it possible to just have a pro forma foundation without real commitment?

Dr. Harrington. To have what?

Staff. A pro forma foundation; that is, having a foundation structure and review which is generally ineffective, without real commitment to the concept on the part of the majority of the physicians in the area?

Dr. Harrington. No.

Staff. You do not think it is possible to simply have a structure without form or substance?

Mr. Thompson. Dr. Harrington's memory is possibly a little short.

Dr. Harrington. Thanks a lot.

Staff. Mr. Thompson, you work for Dr. Harrington?

Mr. Thompson. I am the executive secretary of the association that he is involved with.

Dr. Harrington. I work for him.

Mr. Thompson. When we started out in our area some 15, 16 years ago, there were 50 percent of the physicians that went along with the concept, probably not really understanding what the concept was.

Involvement, I think here, is the key. If you can get 100 percent of physicians involved in a total concept, fine, they will improve upon it. Knowledge will come out of it. If you can get 50 percent of the physicians involved in 50 percent of the concept, that is better than nothing. If you can get 10 percent, my plea here, as we see it throughout the country, is that sincere, knowledgeable physicians, respected in their communities for the medicine they practice, trying to get themselves involved in peer review, is something that we stimulate. Once they get in and start seeing how medicine is practiced—because most of them think they know, and they do not really know; they know practice in the hospitals, to some degree, that they operate in, but they really do not know how medicine is practiced out in the community—once seeing, once they start seeing, that they are hooked, and with their dedication and involvement they will involve others.

So my plea would be, don't take Dr. Harrington's black-and-white answer to your question as gospel. This encouragement should be as

much—let us encourage as much involvement as we can—even though it is not as much as we would like.

STAFF. Would you want to respond to that challenge?

Dr. HARRINGTON. I would agree with him because actually, what he did not say, when we first started we did not have all this involvement, and we would get a membership application in with a claim form as soon as they got a patient that was a foundation patient, so it started. The doctors who did not belong became aware of the fact, and now they are involved, and this is true in most of the communities.

Dr. BABICH. Religious leaders tell us the soul produces life and the soul of this program is the involvement and dedication of local practicing doctors.

STAFF. How do you motivate them?

Dr. BABICH. By their introduction to the experience. For instance, we have nine neurosurgeons in our community, and we point out to them that if they consider the alternatives, the government clerk or a doctor reviewing his claims and certifying his admissions, and would they please come and help us, as Mr. Thompson stated, once they get involved they become imbued with the apostolic spirit of what the private sector can do.

STAFF. You mean fear operates?

Dr. BABICH. Yes, that's another way of saying it.

STAFF. Do you see any role for the nonmedical man in utilization review?

Dr. HARRINGTON. I do.

Dr. BABICH. I do, too. We are going to need computer consultants, administrators, actuaries, many other people.

Dr. HARRINGTON. We need—there are many things we do not know. This has to be a marriage of government, administrative people, electronic data processing people, secretaries, physicians. No one of these people I named is more important than the other. We need all of them to get this job done.

Now, you cannot make a decision on whether my hysterectomy that I took out was right or wrong. Neither can Dr. Bramham—he is a pediatrician—so that the review of this kind of thing comes down to a professional soul-searching.

On the other hand, you, as the administrator of our foundation program, can bring to the gynecologist, "Here is Dr. Harrington—or whoever—"taking out too many uteruses. Here are the statistics that we have on him."

So, it is a partnership in administration and review.

Dr. BABICH. Actually, the quality of care with this program goes up in the community instead of down, and nobody is deprived of adequate hospitalization. Now that we have "muscle," so to speak, we can say, "Doctor, the program will not certify admission or payment for this or any unnecessary operation."

In the past, doctors never had, or assumed, this muscle, and unnecessary diagnostic hospitalizations have been allowed to continue.

STAFF. My last question: Do you have any explanatory material describing the review procedures that you have in effect in San Joaquin, and Sacramento, that we could include in the record?

Dr. BABICH. Yes. Our secretary submitted that, the brochure called CHAP. It is a step-by-step description of how this plan developed and operates in Sacramento; you have that in your file.

STAFF. Thank you.

Dr. BRAMHAM. These are the actual instructions to the nurse, instructions that have been mailed out to our practicing physicians, and the instructions that are mailed to the hospital administrators.

STAFF. For the benefit of others who will be reading the hearing, it will be quite helpful to include it in the record.

Mr. DOCHTERMAN. We have extra copies for distribution.

STAFF. Thank you, gentlemen, very much. Pursuant to the announcement of the chairman, the committee will meet at 10 o'clock tomorrow morning.

(Whereupon, at 1 p.m., the committee adjourned, to reconvene at 10 a.m., on Tuesday, June 16, 1970.)

MEDICARE AND MEDICAID

TUESDAY, JUNE 16, 1970

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE-MEDICAID
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Clinton P. Anderson (chairman of the subcommittee), presiding.

Present: Senators Anderson, Long, Ribicoff, Williams of Delaware, Bennett, and Curtis.

Senator ANDERSON. The first witness this morning is from the American Pharmaceutical Association.

STATEMENT OF DR. WILLIAM S. APPLE, EXECUTIVE DIRECTOR, AMERICAN PHARMACEUTICAL ASSOCIATION; ACCOMPANIED BY JAMES D. HAWKINS, ASSISTANT EXECUTIVE DIRECTOR; AND CARL ROBERTS, DIRECTOR, LEGAL DIVISION

Dr. APPLE. Thank you, Mr. Chairman. With your permission, I would like to have our entire statement put into the record, but I will only refer to certain paragraphs on stated pages in order to expedite and conserve your time, Mr. Chairman.

Senator ANDERSON. Thank you very much.

Dr. APPLE. The American Pharmaceutical Association is the national professional society of pharmacists. Its approximate 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists, and pharmacy students. I am Dr. William S. Apple, executive director of APhA. I am accompanied by Mr. James D. Hawkins, assistant executive director, and Mr. Carl Roberts, director of the APhA Legal Division.

Mr. Chairman, we are here this morning to bring to the attention of this committee several problems facing pharmacists in connection with medicare and medicaid. We also hope to offer some possible solutions to these problems. We think there is an important parallel between our thoughts about pharmaceutical services and the report and recommendations of your full committee staff published on February 9, 1970, which relate to institutional and physician services.

Probably the most serious problem faced by pharmacists in connection with these programs is their inability to obtain prompt reimbursement from fiscal intermediaries, in the case of the medicaid program, and institutions to which they may provide pharmaceutical services under medicare. Just like physicians, hospitals and other providers, pharmacists must pay for purchases and meet payrolls and

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other operating expenses. Generally, pharmacists do not have access to cash reserves which can be used for these purposes. When forced to wait 4, 5, or 6 months for reimbursement of their claims, pharmacists frequently must borrow operating capital to meet their own expenses. As this committee well knows, the cost of borrowing, particularly at this time, is a significant expense—one for which the pharmacist is not compensated.

Senator LONG. I might just stop you right there. Why could we not offset that by making some sort of partial payment or else just an estimated payment and then settle up later? Is that recommended in your statement?

Dr. APPLE. Senator Long, we have a similar type of recommendation that I will come to very shortly.

Senator LONG. Fine.

Dr. APPLE. I would say what you have suggested certainly would be most acceptable to the pharmacists of the Nation.

In the vast majority of claims for pharmaceutical services, better than 50 percent of the total claim amount represents reimbursement to the pharmacist for the cost of the drug product for which he has already paid in advance. Because of this fact, pharmacists are caught in another trap. Where States have run out of money for their medicaid programs, their simplistic solution to the problem has been to impose an across-the-board flat percentage reduction on the claims of providers. The effect of such action on pharmacists is to virtually eliminate, or at least substantially reduce, the pharmacist's compensation for his services. To cite an example, it is not unusual for pharmacists to dispense prescriptions where the acquisition cost of the drug is $10. Assume that the professional fee established by the State is $2, making the total reimbursement claim for the prescription $12. If the total claim is reduced by 15 percent, or $1.80, the pharmacist is left only 20 cents compensation for his professional services after he is reimbursed $10 for his out-of-pocket cost of the drug. Even if the acquisition cost of the drug is as low as $5, and a similar proration is effectuated, the pharmacist is deprived of more than one-half of his normal professional fee.

Pharmacists have also been without remedy and forced to absorb substantial dollar losses because of inadequacies in the system for the identification of eligible medicaid recipients. Thus, pharmacists have dispensed required medication on valid prescriptions, in good faith, only to have their claims rejected when it was later decided that the patient was not an eligible medicaid recipient.

All of the problems that I have described are either exclusively or largely attributable to failings of fiscal intermediaries responsible for administration of medicaid programs and their lack of understanding, and in some cases concern, about the profession of pharmacy and the unique problems experienced by pharmacists. We would point out to the committee that pharmacy has its own capacity to provide fiscal intermediaries for pharmaceutical services and could be expected to do a far better job than that we have experienced thus far.

We have been discussing problems experienced by pharmacists where reimbursement for pharmaceutical services is received via a third-party fiscal intermediary. These problems are compounded in many instances, because the pharmacist's reimbursement is funneled by the

third-party fiscal intermediary through still another party, the institutional provider such as small hospitals, nursing homes, and extended-care facilities. Such institutions which do not maintain their own on-site pharmaceutical services look to the community pharmacists to provide such service on a contract basis. This type of arrangement has often placed pharmacists in an untenable position in at least two ways. The first results from the fact that institutional providers have refused or failed to reimburse pharmacists for their services even months after the amounts for such services had been billed to the State and paid to the institutional provider. We know, for instance, of a small independent pharmacy in California which, at one point, had substantial accounts receivable more than a year old from two nursing homes. The pharmacist knew that the nursing homes had been paid by the State on a regular basis. In this instance and in others institutional providers have used as their own operating capital funds which were due and payable to pharmacists and probably other suppliers to the institution. In the case we have just described, the pharmacist was ultimately forced to threaten lawsuits to collect the amounts due him. The result: He lost the accounts of both nursing homes.

We believe this practice could be eliminated if institutional providers were required to certify before receiving payment for amounts then due from the program that funds they had previously received had been disbursed to their suppliers. This type of requirement is incorporated in the laws of several States, for example, those relating to alcoholic beverage control, so that no party in the chain of distribution can put off any other party to whom a financial obligation is owed on the grounds that he has not received payment to which he is entitled.

Senator Williams. How far back would you say you should carry that requirement? Should we check if the pharmacist is paying his bills, too, or where would you stop?

Dr. Apple. Senator Williams, I think if we carried that requirement back to the immediate party paid by the third party reimburser, that would be sufficient. I think we only have to go one step back in the chain.

Another possible solution to this problem, at least so far as pharmacy is concerned, would be to require that the pharmacist's compensation be paid directly to him by the fiscal intermediary. This would not only facilitate reimbursement, but would also help to remedy another detrimental situation on which we would now like to focus.

As we have indicated, many health care facilities such as small hospitals, nursing homes, and extended care facilities, many of whose operations are supported directly or indirectly by Federal funds, do not maintain their own "on-site" pharmaceutical services. Rather, they look to the community pharmacist to provide such service on a contract basis. Naturally, in most situations, there is competition among pharmacists for such contracts without being solicited for "under-the-table kickbacks."

At this point, Mr. Chairman, I would like to read just two of the letters received recently, that are attached to the back of this testimony. The first is under date of June 2. It says:

Gentlemen, I am returning and thanking you for the use of the film strip and recording on pharmaceutical service in the nursing home. This is a very good

production and should be useful to some people, I suppose. I found it to be of no help to me. I have just lost the nursing home that I have been the consultant for, for the last six years since I will not pay a 15 percent kickback as I was told I must by the minister who is the administrator of this church-owned home. I am finding out much to my dismay that pharmacy might be a profession, but there are very few if any professionals in it. We have two large homes in our town that are completely sewed up by an ex-member of our state board of pharmacy through a percentage kickback arrangement. Nice deal, huh? I am 35 years old, out of Pharmacy School for 14 years and have owned my own professional shop for eight years and I believe the long haired kids are about right. The Establishment is a bunch of crap. Professionalism will never get off the ground in pharmacy as long as we have to put up with the dollarhoos, discount merchants, and hyprocracy that we have in this town and state.

The other letter, which we have not identified at the request of the sender, I would like to read just two paragraphs from:

As I stated before, the patient, or their families, have free choice of pharmacist, and again, we have 95 percent of the business in that home. The new director has been told, by Social Welfare and Medicare people, that it would be best if the nursing home chose one pharmacy to supply all of their patients with their pharmaceutical needs. He would like to do this, because it really would make his billing procedure a little more simple. Many of the people at his home are receiving some type of aid, where the government, the state, or some welfare association pays a certain amount of the drugs, and the family, or someone else has to pay the rest. He has, therefore, approached me with the idea of our billing the home for all of the prescriptions delivered, during the month. Of course, in the back of his mind is the idea that we will pay him to collect the bills for us.

This new administrator, by the way, is not looking for a kickback, as he formerly worked in a home in the outskirts of Philadelphia, that was owned by physicians who had a 20 percent kickback with the local pharmacy. He found this to be not only distasteful, but the pharmacy that was providing the service was not doing a proper job and made many, very serious errors in the dispensing of prescriptions, but this case, his hands were tied. What he is looking for is a cash discount. I do feel that it is quite in order for me to participate in this manner, because he would be paying me promptly each month for the accounts of 95 people, some of whom do not pay me, not only monthly, but wait four, five, or six months. It would save me a good deal of trouble to send one statement, instead of 95, and of course, would greatly help my cash flow, to be promptly paid.

Senator RIBICOFF. Doctor, I am just curious. Is it fair to assume that kickbacks in the pharmaceutical field is a very widespread practice?

Dr. APPLE. Well, Senator Ribicoff, with regard to the nursing home situation, it is one of the worst we have experienced in the history of our profession. It has been virtually a gun to the head of the pharmacist—you will not get in the door without a kickback.

Senator RIBICOFF. What's your estimate of the additional cost to the program due to the kickback? Because very obviously, if a man has to pay a kickback, he is adding that to the bill so he can make a fair profit. So the overall bill to the basic social security fund is increased. Is that not true?

Dr. APPLE. Sir, we would agree with that conclusion and our estimate is that the range would be somewhere between 15 and 20 percent.

Senator RIBICOFF. And have you any idea, has the staff any idea of what the overall cost of pharmaceuticals are in the overall billing?

The staff tells me that that represents about $400 million a year in medicaid. So if it is 20 percent, that is $80 million.

Dr. APPLE. That is right, sir.

Senator WILLIAMS. Do you think that would be eliminated to a large extent by direct billing from the pharmacist to the medicare and medicaid programs?

Dr. Apple. Senator Williams, I think a good share of it would be eliminated. Obviously, there is always going to be some pressure on. As long as the nursing home administrator is in the position of saying, you are fired, we are going to hire another pharmacy consultant, or we are not going to use your pharmacy, we are going to use "X" pharmacy, there is an opportunity for this. But I think through the billing procedure, they have found the facilitating means of accomplishing the deed, if you will.

I think on the other hand, if these types of illegal activities had to be pursued in a way in which they could not be covered up through the billing procedure, that would retard the situation.

Senator Williams. But if these are prescriptions, can the nursing home direct which pharmacies fill them?

Dr. Apple. Senator Williams, our first concern is the patient in the nursing home. After considerable study of this matter, we decided that the nursing home could best be served by having one pharmacy consultant aware of the complete operation of the nursing home, the staff that is available to them, the methods that are used to dispense the drugs to those patients, and preferably to obtain the drugs from one particular source—that is, one particular pharmacy—on a regular, routine basis. We find that this is the most economical system to arrange for the delivery of, the dispensing, the supervision and utilization of drugs in a nursing home or extended care facility. In other words, if we had 50 different pharmacies delivering 50 different prescriptions to a given nursing home every few days, I think we would have considerably more cost in the handling of the drugs inside the nursing homes and other problems that are generated by the need to control the drugs actually given to the patient on a daily basis.

Senator Williams. Do not these patients get these prescriptions from the doctor and can't they have any friend go to the pharmacist to get the prescription filled?

Dr. Apple. Well, no, many of the nursing homes, of course, and extended care facilities have regulations which say to the patient, when you come in here, you cannot bring any medication with you and we will provide all the medication. That is a prerequisite to entering into the facility.

Senator Williams. Why do we have to recognize the right of the nursing home to control where they are bought?

Senator Long. Is it not because most of these people are just lying in bed and somebody has to bring it to them?

Dr. Apple. Senator Long, you are right. Good control of a prescription would not permit handing the entire hundred tablets or 60 tablets to that patient. They have to be set aside and a daily dose dispensed to that patient. I think we would have utter medical chaos inside the nursing home if every patient had complete access to the full quantity of drugs that was just prescribed for him on a given day.

Senator Bennett. Mr. Chairman, many of the patients in nursing homes are solitary, with very few friends. They have been put there to get them out of the way, unfortunately. And if they get visitors, it is once a week or once a month and they would have a terrible time trying to handle their own drugs—I think.

Dr. Apple. We would agree with you, Senator.

Mr. Chairman, if we could turn to the top of page 10.

Presently, approximately 12.5 million prescriptions per year are dispensed to nursing home and extended care facility "in-patient." It is virtually impossible for the Government to monitor and audit the reasonableness of charges for this volume of prescriptions. On the other hand, there are only approximately 52,000 pharmacies in this country. We believe that to remedy the situation there should be a general Federal requirement that compensation for pharmaceutical services have two components: (1) reimbursement for the cost of the drug; and (2) a specific professional fee for the pharmacist's services.

Senator RIBICOFF. I am curious about this. This is very interesting. You represent the professional pharmacists association. Do pharmacists—would they go for this? I have always been under the impression that they would fight tooth and nail against this type of formula. Do you think pharmacists would be willing to take this type of formula?

Dr. APPLE. Senator Ribicoff, the history of the matter is that pharmacists have preferred the margin or markup concept which was fostered by the pharmaceutical industry. In other words, the more expensive the drug, the more profit you would get out of it. So historically speaking, many pharmacists still think this way. I would say that trend started to change about 10-years ago and you now have in many of the large States medicaid programs pharmacists being reimbursed strictly on the basis of the acquisition cost plus a fee, for example, the State of California, which has one of the largest medicaid drug programs.

Senator RIBICOFF. And this, of course, would lead to some successful package of which our embattled chairman has been talking about, the use of generic drugs. If this went into effect, I could see a very substantial saving, because this would give a boost to the utilization of drugs generically. Then if the pharmacist were getting a fee for his services, then he would not care very much whether it was "X" or "Y" or his brand; he would be getting paid for his services being rendered and then he would be interested in making sure that the drug being dispensed was the best quality that could be acquired the cheapest.

Dr. APPLE. We would agree that the pharmacist ought to function in that capacity as the patient's purchasing agent rather than the manufacturer's selling agent. But this idea is more than a fantasy, Senator. It is not only being implemented in medicaid programs, but United Auto Workers, when they started their prepayment drug program followed this procedure. Blue Cross, in offering prepaid pharmaceutical services throughout the country, has put every one of its plans on a cost-plus-fee basis. And we have a number of pharmacists who have shifted to this type of charging for their services with the general public, and very successfully.

Senator BENNETT. Mr. Chairman, could we have an example of how this works? For instance, here is a prescription the value of which at cost is $2.50. What type of fee would the pharmacist charge for pouring those pills out of a bottle, putting them in another bottle with a label for $2.50. Would it be a $5 fee or $1 fee?

Dr. APPLE. Well, Senator, the pharmacist does more than just that, but we will not get into a description of his activity. But to answer your question, the prevailing fees in the United States right now run

from about $1.60 or $1.70 to a high in California of $2.35, where the pharmacist is using a fee. So in other words, if it cost $2.50, you would pay $4.85 in California.

Pharmacists who use the markup system generally use a 50-percent markup or 100 percent of cost, so you would be paying $5. It could be argued that there is not much difference there. On the other hand, when you get into the prescriptions where the cost of the ingredients is going to be $5, $7, $9, then you have a different type of situation.

Senator BENNETT. The fee is still not more than $2.35?

Dr. APPLE. If California, that is exactly what it is under the State medi-cal program.

Senator RIBICOFF. In other words, the fee is a set fee irrespective of the cost of the ingredient?

Dr. APPLE. That is right, sir.

Senator BENNETT. Or irrespective of the responsibility of the pharmacist in putting the prescription together? In many cases, he has to blend certain drugs he has in stock. In other cases, he just reaches down for a bottle and pours some pills out and put a label on them. But the fee is the same in every case?

Dr. APPLE. Yes, it is all averaged in. The fee is based on the pharmacist—the State actually did a study to determine what the cost of providing pharmaceutical services was in California. To that, they added roughly a 10-percent return as net profit, and arrived at the $2.35.

Senator WILLIAMS. Has the quality of service been just as good under this fee system as it was under the other system?

Dr. APPLE. Well, Senator, according to reports made by the welfare people in California, in many ways, the service has been better and the State has been able to save considerable funds because the pharmacist no longer has a vested interest in the cost of the drugs he is dispensing.

Senator LONG. Because as long as you leave it on a markup basis, you have the incentive for someone to order the highest cost drug. But if you pay the pharmacist on a professional fee basis, then there is no reason for him to increase the cost of the drug.

There is one way we might handle this, and I do not think the drug companies would object to it, oddly enough, even though you might get the drugs cheaper this way. It might be worth considering simply letting the Government buy the drug and then ship it to a pharmacist and let the pharmacist dispense it, adding his professional fee. That way, instead of having the druggist worry about which drug company might have the best quality drug, the Government could worry about all that. The Government can inspect the plants and the Government can test the drugs that are delivered. That would be one way of doing it.

Dr. APPLE. Of course, another solution—the one you described, Senator, I have not studied the costs of doing it that way. You would have an accountability of the inventory, which really would belong to the U.S. Government, in somebody else's hands, and there would be a certain amount of accountability the Government would require.

Senator LONG. Well, maybe we could buy it and sell it to you at cost. What's your offhand reaction to doing it that way?

Dr. Apple. My offhand reaction would be that it would mean the death of the pharmaceutical industry, because the pharmaceutical industry over the years has given the Government their products at less than incremental cost. In other words, the general public has subsidized the cost of drugs purchased by the Federal Government and I think the pharmaceutical industry would be put out of business, very frankly.

Senator Long. Well, if they are selling us drugs below cost now and they are going to do business on a bigger basis, obviously, they have to start charging a fair profit.

Dr. Apple. Right.

Senator Long. That is all right with me. I am against anybody selling me something below cost. As far as I am concerned, he ought to be selling at a price at which he makes a profit.

Dr. Apple. Take oral contraceptives. Right now, the Government is paying 18 cents a cycle. A pharmacist has to pay $1.44 for that same quantity of the drug. Now, obviously, if the industry were to sell all of its capacity at 18 cents, there would not be any profits from any source.

Senator Long. Well, they have no business selling it below cost to any body. In fact, we have some laws against selling below cost in some cases.

Dr. Apple. I am not trying to defend the pharmaceutical industry, but of course, the pharmacist, if he does not have any drugs to dispense because the industry is not making a profit——

Senator Long. One thing you and I need not worry about is people going out of business just because they are bidding. I have never seen that destroy any industry.

Dr. Apple. Well, Senator, the thought just struck me: Instead of the Government supplying the drugs to the pharmacist, why not, by Federal statute, by law if you will, put in there that the pharmacist can buy at the same price as the Government? Give us the privilege of buying our inventory at the same price as the Government, and that is all we will charge the Government.

Senator Ribicoff. But that is pretty impractical. After all, the Government for the armed services, two and a half million people, buys it in such huge lots and any pharmacist, no matter how big, has to buy in smaller quantities. It just does not make sense.

Dr. Apple. Well, have a reasonable price differential.

Senator Ribicoff. One buys in little bottles and the other buys in drums, where you do not have the packaging, the handling and everything else.

Senator Long. It is a lot easier for us to buy it in quantity and provide it to you at our cost than to supply those people, as Senator Ribicoff says, a package of pills for the same price at which they deliver a boxcar load of them to the Government.

Dr. Apple. But the Government has to turn around and break this down and redistribute it. There is an additional cost right there.

Senator Long. As far as the incremental cost is concerned we are having to bear that anyway.

The procedure is something that we will have to work out. As far as your people are concerned, if you are given an adequate professional fee, as I understand it, it does not really concern you as to what you have to pay for the drug.

Dr. Apple. That is right, Senator.

Senator Bennett. Mr. Chairman, may I get into this?

Senator Anderson. Senator Bennett.

Senator Bennett. I have two comments. If the Federal Government is going to buy the output of the pharmaceutical houses and then sell it to the pharmacy, you have set up a completely new system in the United States and the Federal Government becomes the sole customer.

Another point. If the Federal Government is going to buy and sell to the pharmacists at cost the products that he is going in turn to sell to the nursing home or other institution for medicaid, then he has to maintain two inventories. Otherwise, he is going to supply everybody, whether they are in Medicaid or not, out of Government stock.

I would like to turn to this question that the chairman has been discussing about doing business at low cost. I have been in business, and when you said the Government buys the drugs without incremental cost, it means this to me, Mr. Chairman: We manufacture paint in our little business in Utah. The biggest single order of the year is the State highway marking paint. It is a very substantial portion of our potential volume. So when we bid on the State highway marking paint, we take out all our overhead, knowing that if we add that volume to our factory run, we automatically create some savings that we could not possibly have if we were manufacturing that volume to be sold a few gallons at a time. So in effect, we sell below our cost, our total cost of making and distributing paint in the normal channel. But in the end, we do not lose any particular profit because of the effects of the volume on the length of the runs and the daily volume.

Now, I wonder if that is not part of the problem of the pharmaceuticals? If they can get an armed services contract, their machinery already being set up and their supplies already located, they can supply that at a lower price than they can supply the same drugs through the retail channels if they did not have that added volume. I am scared to death of any idea that says the Federal Government shall buy the drugs and distribute them.

Senator Long. The thing that concerns me is that we are buying a huge amount of these drugs anyway. Now, I know that we have to pay for the cost of producing the drugs. That is no problem. I know we have to pay for the cost of dispensing them—no problem. I am just wondering if it is more efficient for us to pay for the cost of Squibb and Pfizer fighting it out just one time before a fair judge up here as to whether Squibb is better than Pfizer or Pfizer is better than Squibb, rather than for us to pay the cost of them fighting that argument out 52,000 times across the country, not just Squibb and Pfizer, but 10 other companies all doing that. What are those salesmen telling them? They are all telling them the same thing, that one company's is the safest product to begin with. What he is arguing with you is that he can buy you something better than the other fellow. If he can prove it, he is entitled to be the sole source, but if he cannot prove it, he will have to compete for the business.

It is a very inefficient operation that we are paying for, when we have to pay for the cost of somebody debating that issue with every doctor and with every pharmacist all over the entire United States, when either the product is superior or it is not superior, and in most

cases, you cannot tell the difference. If you can tell the difference, you should not be buying the inferior product.

Dr. Apple. Senator, there are other solutions, of course. State laws in most States today prohibit the pharmacist from exercising his judgment in selecting the brand of product, the so-called antisubstitution laws. If the Congress were to get rid of those laws by overriding the State statutes and giving the pharmacist an opportunity to exercise his judgment, and he is on a fee basis, he might as well use a $2.25 Prednisone made by Upjohn, or Merck Sharp & Dohme as to use a $11 Prednisone made by Schering or Parke Davis. And of course, the program could have upper limits for the acquisition cost of each drug.

We now find that our neighbors north of us are moving in this direction. Even the British Columbia Medical Society, and medical societies are the last to agree to things like this as you might well suspect, have agreed that the pharmacist should have the right to dispense a different product—that is, a different brand—than the one that is prescribed unless the physician puts on the prescription "no substitution."

Now, in most cases, we could save considerable funds and some of the programs like Medi-Cal have recognized this. In the State of California, for example, it does not matter what brand of tetracycline is being prescribed for a Medi-Cal patient, the pharmacist is fixed, locked in, with an acquisition cost of so much a hundred and he has to buy a product that will meet that top acquisition cost. If he does not, then he has to take the difference out of his own pocket and he is not about to do that, nor should he have to.

Senator Long. We can get into that later on. The thought occurred to me that any time we are buying something—that is in most instances is all the same thing—you should not be required to keep a dozen different products on your shelf or 20 different kinds, all the same thing. It is just like sugar. Buying sugar from the grocery store. There is no particular reason why you should have to carry 50 different brands of aspirin tablets. Most people just want aspirin as long as it is all the same thing.

If you are operating a grocery store, if you are required to maintain 50 different brands of sugar, it is sure going to cost you a lot of money to maintain that. You also have an inventory problem of keeping some of these drugs from spoiling when you have to keep 20 or 50 different kinds on the shelves.

Pardon me for getting into all this. Suppose you go ahead.

Dr. Apple. The bottom of page 10. The Kansas Pharmaceutical Association, in cooperation with University of Kansas personnel, and the Kansas Department of Social Welfare have devised a new method of reimbursement for pharmaceutical services in the Kansas medicaid program. It will take effect on July 1. APhA believes this unique and workable method will equitably and responsibly serve all drug insurance programs whether government sponsored, as under title XIX or the envisioned out-of-hospital prescription benefits under title XVIII, or private insurance programs.

Mr. Chairman, we would like to briefly outline the principles of the new reimbursement method developed in Kansas. This method goes far in providing each pharmacist reasonable reimbursement, while

simultaneously providing government simplified preaudit fiscal controls rather than expensive postaudits which are ineffective in controlling costs.

All pharmacies participating in the Kansas plan will be required to file their average professional fee with the State welfare department. The fees will then be ranked from lowest to highest. The highest 10 percent will reduce automatically to the 90th percentile and no fee paid will exceed this amount. All pharmacies submitting fees will be required to submit financial data to justify the fee filed. Any pharmacy which does not submit a fee will automatically be assigned the lowest fee requested. Fees may be resubmitted annually, or when in the judgment of the department of social welfare, reevaluation is necessary.

We believe that the Kansas plan is equitable to all parties and we recommend that it receive the consideration of this committee as it studies improvements in the medicare-medicaid programs.

Senator RIBICOFF. May I ask a question, because I think the question of procedure and public pressure is involved here. When this was first proposed to the pharmacists in Kansas, what was the reaction and how did you develop acceptability?

Dr. APPLE. Kansas has been on a markup plan, the conventional thing that you referred to earlier, Senator Ribicoff. When this was first approached, of course, it involved an educational program of going out to district meetings and discussing the philosophy of the system. Obviously, no more could be discussed than the philosophy because of the antitrust laws. We could not get into the specifics of numbers, but you could talk about the mechanism and the principles that were involved. Then the State, with the aid of the university and some pharmacy consultants, developed a rather extensive questionnaire in order to ascertain the financial data required to substantiate the fee claimed by an individual pharmacy. We thought at first, looking at the questionnaire, and it was extensive—I think it was around 20 pages long, of that magnitude, Senator—and they had an excellent response. Many pharmacists rebelled first at the thought of revealing their cost of business to the State.

On the other hand, when it was explained to them that the State wanted to assure them of a fair return for their services to pay them the fee that they were asking, that the State was entitled to some backup information to substantiate it and that the information, of course, would be kept confidential, the Welfare Department had overall an excellent response from the pharmacists in Kansas.

Now, keep in mind this is being done by HEW in Kansas because of the voluntary cooperation and attitude of the pharmacists in Kansas, especially their leadership, and the fact that HEW wanted to try this out in a small State, with a relatively small universe of pharmacies.

Senator RIBICOFF. In other words, from your experience, Kansas generally is a conservative type of State and there, the pharmacists accepted it after explanations and grumbling, but they went along. How long has it been in effect now, this program?

Dr. APPLE. The actual reimbursement under this new method will start on July 1.

Senator RIBICOFF. Oh, it has not gone into effect?

Dr. Apple. No; they have spent the months of March, April, and May obtaining all the information, arraying the data, and getting the new forms out, tooling up for it. The effective date of it is July 1.

Senator Ribicoff. So we could not know yet what the experience will be under that?

Dr. Apple. No; we do not, sir.

Senator Ribicoff. And how much will be saved in the overall dispensing part of the pharmaceutical situation?

Dr. Apple. No; it will take some experience. But keep in mind that one of the gripes the pharmacists had about the fee method was that initially, we had to start with one average fee for every single pharmacy. And obviously, all pharmacies do not have the same operating costs.

Initially States were faced with an implementation deadline, so they proceeded by starting with one average fee. Now that we have had some time to get into it, we have been able to come up with the so-called Kansas method, which will take into account the variable operating costs of the individual pharmacy. In other words, one pharmacy may say to the State of Kansas, I will dispense prescriptions under your medicaid program for cost plus $1.90. Some other pharmacy may say we need $1.95 or $2.05. Someone else may say, we can do it for $1.65. The State, of course, will pay what the pharmacists claim, knocking off a top 10 percentile.

Senator Ribicoff. You know, I was with a Nobel prize winner in medicine yesterday, who said, the trouble is most people do not ask the simple or foolish question. He said, I always like to ask the simple or foolish question. He said when you talk about percentile, knocking it off, give me a dollars and cents idea of what you are talking about.

Dr. Apple. Let's say there are 500 pharmacies in Kansas that file fees. The fees run from $1.60 to $2.70. You go up the ladder and you count, take the first 90 percent up. Let's say that turns out to be $2.25. The pharmacy which has filed a fee of $2.70 only is going to get $2.25.

Senator Ribicoff. In other words, you go up anywhere between $1.60 and $2.25 will be reimbursed, but anything above $2.25, your reimbursement will be $2.25.

Dr. Apple. Yes.

Senator Ribicoff. Now, let's say that you find that the runs are toward the top of $2.25, and yet there are a substantial number in the $1.60's or $1.75's or $1.80's. What's your attitude, then? Do you start figuring that the pharmacists that are up at $2.25 are inefficient and maybe they should not be and you have paid for their inefficiency? How is that going to work out?

Dr. Apple. I do not think you can say that because one pharmacist files a fee of $2.25 and another pharmacist files a fee of $1.65, that one is more efficient than the other. One may be in a different type of neighborhood or a different type of community where the cost of doing business is considerably less. Even in as rural a State as Kansas, you have some metropolitan communities. Salaries are higher for pharmacists in the metropolitan or larger centers, the cost of rent and other operating expenses are higher. So he may need a higher fee. That is one variable.

The other variable is the extent of services that the pharmacist wants to perform for the individual.

Senator Ribicoff. In other words, whether it is delivery or——

Dr. Apple. Not only delivery and charge, but more important from the medical viewpoint, whether or not he is keeping patient records, whether he is keeping track of all the medication the patient is using, possible incompatibilities, reactions—all these things take time. What you are paying for in his fee is his time and knowledge.

Senator Ribicoff. Mr. Chairman, I just want to commend the Chair and its witnesses for the type of information that is being given us today, because we are getting some practical experience from knowledgeable people that can be very valuable. We are not just dealing with theories. I just want to commend the witness and the Chair for this type witness, Mr. Chairman.

Senator Anderson. Thank you.

Senator Curtis?

Senator Curtis. When you talk about a fee, that is the cost of the drugs and other ingredients in the prescription plus a fee?

Dr. Apple. No, Senator, it is not. When we talk about a fee, we are excluding the acquisition cost of the physical product.

Senator Curtis. That is what I asked you before.

Dr. Apple. Included in the fee are all the operating costs for providing the service, plus the necessary return on investment for being in practice.

Senator Curtis. So it is the ingredients plus a fee?

Dr. Apple. Yes, sir.

Senator Curtis. Are the ingredients at wholesale, at the figure that the druggist acquires it for?

Dr. Apple. Yes, sir. When we refer to an acquisition cost, we mean the figure at which the pharmacist actually acquired the inventory.

Senator Curtis. No markup on that?

Dr. Apple. No markup on that.

Senator Curtis. Even though he may have to hold the inventory for some time?

Dr. Apple. That is right, because we have integrated that operating cost in the fee component.

Senator Curtis. I see.

Do you make any allowance for any unusual prescription that does not come along very often?

Dr. Apple. Well, pharmacists still compound a significant number of prescriptions, even though percentagewise, it is a small percentage of the total number of the prescriptions dispensed. Let us assume that I am a specialist of some kind and I want to use a specific ingredient and I write a prescription that the pharmacist has to compound. Dermatologists for example, do a great deal of this. Some pharmacists may find that because his volume is made up of, say, 50 percent of his prescriptions are compounded and 50 percent are prefabricated, his overall fee may have to be slightly more than otherwise. Or in some instances, pharmacists have two fees. They have a fee for the prefabricated drug and they may have a separate fee when they have to take considerable time to compound some individual prescription.

Senator Curtis. That is all, Mr. Chairman.

Senator Anderson. Go ahead.

Dr. Apple. We are on the top of page 13.

Mr. Chairman, we believe that "kickbacks" cannot be entirely eliminated so long as providers compete to serve small hospitals, nursing homes and extended care facilities. However, we believe the medicare and medicaid programs encourage the demand and receipt of illegal payment because pharmacists' reimbursement is funneled through these facilities. As we have suggested, we believe that the problem could be controlled further by adding pharmacists to the present list of providers of service under part A of medicare and also when out-of-hospital drugs are added to that program. Also, all payments for pharmaceutical services under medicaid should be required to be made directly to the pharmacist.

We are greatly disturbed that the "kickback" situation we have described exists. Public opinion condemns all such breaches of public trust. However, the most bitter complaints we have received are from pharmacists who have, in fact, been subjected to "kickback" demands. By far the vast majority of the Nation's pharmacists conduct themselves with both legal and ethical propriety. Unfortunately, there are some who fail to measure up to their obligations. With assistance from those creating and administering Federal programs, we believe that pharmacy can eliminate this unfair competitive practice and devote its best efforts to the primary objective of these programs, providing pharmaceutical services at reasonable cost for persons in need of them.

In this connection, we wish to bring to your attention the results of a research project recently completed by Mr. Jordan Braverman, research associate in my office. We are providing copies of his report, "Nursing Home Standards . . . A Tragic Dilemma in American Health" for the committee's use. The report goes far beyond the subject of pharmaceutical services and reflects our concern with the entire problem of the delivery of health care services.

The report of your committee staff earlier referred to makes reference on page 136, to apparent program abuses arising out of physician ownership of facilities. We would like to relate this problem to pharmaceutical services.

Tomorrow morning we are scheduled to appear before the Subcommittee on the Consumer of the Senate Commerce Committee to discuss S. 1575, introduced by Senator Hart. This bill would prohibit Federal financial participation in the cost of drugs or devices under any program where a medical practitioner owns an interest in a drug company, or pharmacy, or, generally, when he dispenses the drug or device himself.

We emphasize that the failure to legislate with regard to the problem in the drug field has unquestionably, in our view, created the "hands off" climate in which these abuses can flourish in medicare and medicaid generally. This failure to legislate has also made possible one of the most indefensible decisions made by Government officials in connection with the medicaid program. The Department of Health, Education, and Welfare's handbook of public assistance administration entitled "Medical Assistance Programs under Title 19 of the Social Security Act (Supplement D)" was issued on May 16, 1967. Section D–5150 originally specified that Federal financial participation with regard to prescribed drugs:

> * * * is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof.

On June 28, 1968, the Administrator of HEW's Social and Rehabilitation Service announced a change in this policy which now permits Federal financial participation with respect to prescribed drugs in all cases involving physician dispensing:

> Federal Financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed, authorized practitioners in accordance with what the practitioner must do on his written prescription and maintain records thereof.

Since the earlier HEW policy had permitted Federal financial participation relating to physician dispensing where adequate pharmaceutical services were not available from licensed pharmacists, it insured that medicaid patients always would be able to obtain needed medication. What could have influenced responsible HEW officials to relax their stand? In our opinion, it was physician-backed pressures relating not to health care, but to money. The change in HEW policy did absolutely nothing to increase the availability of pharmaceutical services to medicaid patients.

Finally, Mr. Chairman, rather than discuss only problems experienced by pharmacy in connection with medicare and medicaid, we would like to suggest a significant contribution we believe pharmacists could make to these programs and to prepaid prescription benefit programs generally. This contribution relates to the task of drug utilization review, which we believe is a necessary requirement for prepaid prescription programs. A formalized drug utilization review procedure will be necessary to insure that the highest quality health care is being provided patients in relation to program costs. Such a review procedure will also be necessary to control and possibly even reduce program costs.

We emphasize that the most important aspect of drug utilization review, and the one for which the pharmacist can make the greatest contribution, is in the assurance of rational drug prescribing and dispensing practices. At present, there is great concern among the professions of medicine and pharmacy, as well as among those responsible for the administration of health care programs, about the lack of rational prescribing evident in today's health care system.

The object of rational prescribing is to provide the patient with the right drug in the right amount at the right time. From this definition, and the variables inherent in it, you can see that rational prescribing cannot be expected to flow from inflexible laws, regulations, or statements of policy. What is needed is a viable review structure and process which can address itself to particular problems relating to particular drugs, particular diseases and practices. We believe that such a process includes the much discussed concept of "peer review" but goes beyond it, in that it contemplates a multidisciplinary approach to the problem. It is in this multidisciplinary context that the pharmacist can and must function if drug utilization review is to achieve its objectives.

Clearly, drug utilization review can be expected to consider program costs and administrative burdens. For many of the problems we anticipate, pharmacists are the best informed, if not the only source of required information. The pharmacy input is necessary, along with input from other health care professions, consistent with today's increasing "team" approach to health care problems.

We would emphasize that drug utilization review with the structure and processes we have only briefly outlined, must be required by legislation and not left to voluntary effort. We urge such a requirement, not only because we think it makes good sense, but also for a very practical reason. We fear voluntary efforts toward this end may experience difficulty in mounting effective drug utilization review programs, because of the fear of many professionals that they may be accused of antitrust law violations. Since the drug utilization review process can be expected to result in decisions which may affect the availability and price of drug products, we believe that the entire process will likely be subjected to antitrust scrutiny. Since the objectives of drug utilization review are clearly not anticompetitive, but are designed to insure only high quality health care at reasonable cost, we believe that such efforts should have the specific legislative sanction of Congress.

We expect that it is only a question of time before Congress sees fit to include prescription drugs as a benefit under the medicare program as is already the case under the medicaid program. Pharmacy stands ready to make its expertise available to the development and success of such a program and generally to assist you to the full extent of our ability with regard to medicare and medicaid.

Mr. Chairman, we appreciate your courtesy in allowing us to appear before you.

Senator ANDERSON. Thank you.

Senator Long?

Senator LONG. I have no questions.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. I want to make sure that I understand just what you mean by drug review programs. Does that mean that the medicaid patient, for instance, someone would look over the medicines that he is being given to decide whether or not they are the right drugs in the right amount at the right time?

Dr. APPLE. It could include that. But I would want to underscore the fact that the review would be undertaken by a group of peers or a health care team. Now, for example, HEW just funded an on-going study in Los Angeles County, Calif. to the extent of about three quarters of a million dollars. So far, that study, which has gone on for 18 months, has computer data for 600,000 prescriptions dispensed to 200,000 patients. Therapeutic and diagnostic indications and drug history are reviewed by a physician-pharmacists board which cautions prescribers who show inappropriate prescribing habits. So far, the study has revealed that the major problem is prescribing too large amounts of drugs.

Senator CURTIS. By whom?

Dr. APPLE. By the physician who initially prescribed the drug.

Senator CURTIS. Then it is something operating with the sanction of the Government as we set up our statute to review the prescriptions that doctors write for their patients, is that right?

Dr. APPLE. That would be correct, Senator.

Senator CURTIS. Who reviews the reviewers? Is the final judgment as to what medicine patients should have then going to be with the reviewing committee?

Dr. Apple. Senator, we have a considerable amount of review going on in the medicare system today. No surgeon goes into the operating room of a hospital without having his surgery subjected to peer review, for instance. We are just saying that a drug review cannot be left entirely to one person or one component of the team. We think the pharmacist-physician team can best undertake utilization review. But we have on-going utilization review today under medicare and medicaid.

Senator Curtis. Well, you have the same thing with the patient who is under neither?

Dr. Apple. Exactly, sir.

Senator Curtis. And it is done with the patient's consent?

Dr. Apple. Well, once you enter the hospital, assume that you as a private patient enter the hospital. When you sign in, you give the hospital the consent to do those things that are necessary in your best interest, and part of it would be if you were going into surgery to have the pathologist look at the removed tissue. I do not think the patient is giving up any privilege of his. All this is being done to safeguard the interest of the patient.

Senator Curtis. Well, but I doubt if the Government can do it.

Dr. Apple. It is not the Government that is going to be doing it.

Senator Curtis. I thought you were asking for a statute requiring it?

Dr. Apple. We said that the Government ought to sanction utilization review. To us that is far different from the Government undertaking utilization review.

Senator Curtis. Well, I can see that point, too, but how far would this be carried? Would it be a spot check utilization review? Are you checking on the judgment and professional qualifications of the writer of the prescription, or are you just checking upon him to see whether or not he is prescribing maybe for his own financial advantage?

Dr. Apple. I do not think it is either, Senator. I think utilization review would work this way—is working this way: For example, in the study I just described, let us assume a given drug had been prescribed by a physician for 50 units to the patient. It may well be that another physician has prescribed 50 units, but in the utilization review process, they find that what the patient needs is three doses of that drug, for an average of 5 days—in other words, 15 units would be the optimum required by that patient.

Now, they might then, in one of their staff briefing, point out that 98 percent of the prescribers have used 15 units of the drug, 2 percent are using 50 units, and in looking into it and discussing with the two prescribers who use the 50 quantity found that they had no particular reason for prescribing 50 units, and it becomes an educational process.

Senator Curtis. Well, then, it does—you are reviewing the judgment and the competence of the person who writes a prescription?

Dr. Apple. In the final analysis, yes, but I do not think in the context of questioning as much as helping to self-educate the practitioner about the use of a particular drug that we are talking about.

Utilization review is not intended as a negative process. It is not intended to impune the reputation of any practitioner; it is intended to help educate him. It is part of the continuing education of any health practitioner.

Senator CURTIS. That is all.

Senator ANDERSON. Senator Long?

Senator LONG. In 1967, your association assisted in the preparation of an amendment which I offered, and you supported it. It was designed to bring some common sense to the payment for drugs in the medicare and medicaid programs and to save this government some money. It included the concept of: one, professional fees, advocated here in your statement; and, two, a range of prices which would include a maximum amount that the Government would be willing to pay for those drugs.

Now, at that time the administration held out—at least there was some argument. The debate was whether we should go forward on that basis or have a study. The Senate voted to act and voted down the study. But the House did not agree to it. Since that time, the study has been made. The study group recommended enactment of my basic proposal. Then the staff of this committee also recommended adoption of the "Long" amendment. The present administration responding to the staff recommendation said: "We agree, it is our belief that adoption of this recommendation would at least save substantial sums of money."

Now, do you still support that proposal?

Dr. APPLE. Senator, our house of delegates has not changed its position with regard to the proposal that you initially offered. I personally have not seen anything in the study done by HEW that would change my opinion.

Senator LONG. Well, HEW agrees with you now.

Frankly, it was your advice and your support that made it possible for the Senate to agree to that to begin with. It is too bad we could not have done it 3 years ago, but I would hope that now it is one of the items that can be passed to save us a lot of money.

Now, it also seems to me that we ought to find a way to outlaw kickbacks. As I understand it, the pharmacists, do not like that kickback system. They only go along with it because they have no choice about it?

Dr. APPLE. That is correct, sir.

Senator LONG. Thank you for a very fine statement.

Senator ANDERSON. Senator Bennett?

Senator BENNETT. I have no questions.

Senator ANDERSON. Senator Ribicoff?

Senator RIBICOFF. No questions, thank you.

Senator ANDERSON. Thank you very much, gentlemen.

(Mr. Apple's prepared statement with attachments follows. A supplemental letter submitted by Mr. Apple, dated June 30, 1970, appears at p. 743.)

STATEMENT OF THE
AMERICAN PHARMACEUTICAL ASSOCIATION

(by William S. Apple, Executive Director)

The American Pharmaceutical Association is the national professional society of pharmacists. Its approximate 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists and pharmacy students. I am Dr. William S. Apple, Executive Director of APhA. I am accompanied by Dr. James D. Hawkins, Assistant Executive Director, and Mr. Carl Roberts, Director of the APhA Legal Division.

Pharmacists provide pharmaceutical services in a number of health care programs financed wholly or in part by the federal government, and particularly

under Medicaid and Medicare. We know that the success of these programs is largely dependent upon government's ability to maintain them under sound fiscal controls. The Title XIX Medicaid program has already been imperiled by runaway costs resulting in emergency federal legislation to ease the financial impact of the program on the several states. This experience as well as many others has illustrated dramatically the necessity for procedures which will keep program costs within projected and authorized limits.

Mr. Chairman, we are here this morning to bring to the attention of this Committee several problems facing pharmacists in connection with Medicare and Medicaid. We also hope to offer some possible solutions to these problems. We think there is an important parallel between our thoughts about pharmaceutical services and the report and recommendations of your full committee staff published on February 9, 1970, which relate to institutional and physician services.

Probably the most serious problem faced by pharmacists in connection with these programs is their inability to obtain prompt reimbursement from fiscal intermediaries, in the case of the Medicaid program, and institutions to which they may provide pharmaceutical services under Medicare. Just like physicians, hospitals and other providers, pharmacists must pay for purchases and meet payrolls and other operating expenses.

Generally, pharmacists do not have access to cash reserves which can be used for these purposes. When forced to wait four, five or six months for reimbursement of their claims, pharmacists frequently must borrow operating capital to meet their own expenses. As this Committee well knows, the cost of borrowing, particularly at this time, is a significant expense—one for which the pharmacist is not compensated.

In the vast majority of claims for pharmaceutical services, better than 50 percent of the total claim amount represents reimbursement to the pharmacist for the cost of the drug product for which he has already paid in advance. Because of this fact, pharmacists are caught in another trap. Where states have run out of money for their Medicaid programs, their simplistic solution to the problem has been to impose an across-the-board flat percentage reduction on the claims of providers. The effect of such action on pharmacists is to virtually eliminate, or at least substantially reduce, the pharmacist's compensation for his services. To cite an example, it is not unusual for pharmacists to dispense prescriptions where the acquisition cost of the drug is $10. Assume that the professional fee established by the state is $2, making the total reimbursement claim for the prescription $12. If the total claim is reduced by 15 percent or $1.80, the pharmacist is left only 20 cents compensation for his professional services after he is reimbursed $10 for his out-of-pocket cost of the drug. Even if the acquisition cost of the drug is as low as $5, and a similar proration is effectuated, the pharmacist is deprived of more than one-half of his normal professional fee.

It is grossly unfair to lump pharmacists in with other providers in such across-the-board reductions in claim payments when such a substantial percentage of the pharmacist's claim reflects an "out-of-pocket cost" for a drug product. We wish to emphasize the difference in these situations between reimbursement for pharmaceutical services and reimbursement for physicians' services. The pharmacist is reimbursed on the basis of his cost for the drug plus a fixed professional fee established by the state, while the physician is reimbursed on the basis of his usual and customary fees for service. A 15 percent reduction in professional fees may be more palatable to physicians when they are permitted to specify what that fee will be in the first instance.

Another example of the reimbursement problems faced by our profession occurred only recently in the State of California. In August of 1969, the Department of Health Care Services instructed the fiscal intermediary administering the state's Medicaid program to require that the prescriber's license number appear on all pharmacists' drug and medical supply claims by April 1, 1970. The intermediary was specifically instructed to meet with pharmacy representatives to make this requirement known to California pharmacists. No meeting was held and the information was not provided the pharmacists. When April 1 passed, however, and pharmacists continued to submit claims without the prescriber's license number, the intermediary, in strict compliance with the instructions of the state agency, proceeded to reject the incomplete claims. The situation has been corrected by the state, but for two months there was unnecessary confusion and the pharmacists of California who were totally without fault, were subjected to unnecessary expense, and had no remedy.

Pharmacists have also been without remedy and forced to absorb substantial dollar losses because of inadequacies in the system for the identification of eligible Medicaid recipients. Thus, pharmacists have dispensed required medication on valid prescriptions, in good faith, only to have their claims rejected when it was later decided that the patient was not an eligible Medicaid recipient.

All of the problems that I have described are either exclusively or largely attributable to failings of fiscal intermediaries responsible for administration of Medicaid programs and their lack of understanding, and in some cases concern, about the profession of pharmacy and the unique problems experienced by pharmacists. We would point out to the committee that pharmacy has its own capacity to provide fiscal intermediaries for pharmaceutical services and could be expected to do a far better job than that we have experienced thus far.

We have been discussing problems experienced by pharmacists where reimbursement for pharmaceutical services is received via a third-party fiscal intermediary. These problems are compounded in many instances, because the pharmacist's reimbursement is funneled by the third-party fiscal intermediary through still another party, the institutional provider such as small hospitals, nursing homes and extended care facilities.

Such institutions which do not maintain their own "on-site" pharmaceutical services look to the community pharmacist to provide such service on a contract basis. This type of arrangement has often placed pharmacists in an untenable position in at least two ways. The first results from the fact that institutional providers have refused or failed to reimburse pharmacists for their services even months after the amounts for such services had been billed to the state and paid to the institutional provider. We know for instance of a small independent pharmacy in California which, at one point, had substantial accounts receivable more than a year old from two nursing homes. The pharmacist knew that the nursing homes had been paid by the state on a regular basis. In this case, and in others, institutional providers have used as their own operating capital funds which were due and payable to pharmacists and probably other suppliers to the institution. In the case we have just described, the pharmacist was ultimately forced to threaten lawsuits to collect the amounts due him. The result—he lost the accounts of both nursing homes.

We believe this practice could be eliminated if institutional providers were required to certify before receiving payment for amounts then due from the program that funds they had previously received had been disbursed to their suppliers. This type of requirement is incorporated in the laws of several states, for example, those relating to alcoholic beverage control, so that no party in the chain of distribution can put off any other party to whom a financial obligation is owed on the grounds that he has not received payment to which he is entitled.

Another possible solution to this problem, at least so far as pharmacy is concerned, would be to require that the pharmacist's compensation be paid directly to him by the fiscal intermediary. This would not only facilitate reimbursement, but would also help to remedy another detrimental situation on which we would now like to focus.

As we have indicated, many health care facilities such as small hospitals, nursing homes, and extended care facilities, many of whose operations are supported directly or indirectly by federal funds, do ot maintain their own "on-site" pharmaceutical services. Rather, they look to the community pharmacist to provide such service on a contract basis. Naturally, in most situations, there is competition among pharmacists for such practice. Many pharmacists have been unable to obtain these contracts without being solicited for "under-the-table kickbacks."

Needless to say, such payments are absolutely unethical from a professional standpoint. Section 5 of the APhA Code of Ethics provides: "A pharmacist should seek at all times only fair and reasonable remuneration for his services. He should never agree to, or participate in transactions with practitioners of other health professions or any other person under which fees are devided or which may cause financial or other exploitation in connection with the rendering of his professional services."

Moreover, those who participate in such schemes undoubtedly aid and abet the recipient in submitting false statements to the federal government, thus violating federal criminal statutes.

In *U.S.* v. *Thompson*, 366 F. 2d 167 (1966) a "kickback" arrangement on a federally financed construction project was held a criminal conspiracy against the United States. Also in many states, these activities violate commercial bribery or other criminal statutes.

Unfortunately, the existence of potential criminal and professional sanctions has not been sufficient to prevent either the demand for illegal payments or accession to these demands by some pharmacists. The problem with regard to nursing homes in Michigan was apparently so great that the pharmacists of that state supported enactment of a provision in the law requiring licensing of nursing home administrators, which provides for suspension or revocation of license for seeking a "kickback" from pharmacists or other suppliers.

We believe this continuing problem is not necessarily attributed to the inadequacy of existing laws, but rather primarily to the practical problems involved in their enforcement. We know, for example, that the Social Security Administration has been greatly concerned about this problem.. Also, the Social and Rehablitation of HEW has made "good character" a requirement for state standards applicable to the licensing of nursing home administrators. However, with limited manpower, even working through state agencies and other fiscal intermediaries, enforcement efforts have been difficult. Moreover, there has been some difficulty in obtaining criminal prosecutions by the Department of Justice in cases which may be uncovered.

This is not difficult to understand, when the relatively small monetary amounts involved in these siutations are compared to those in major fraud cases prosecuted by the Department of Justice. What is needed, in our view, are new approaches to eliminating or, at least, reducing the problem without the necessity of depending on criminal law enforcement. We will suggest two such approaches in a moment.

Before proceeding, Mr. Chairman, we wish to make clear that we are not objecting to, or discussing situations in which legitimate discounts are granted hospitals, nursing homes and extended care facilities by pharmacists. Present HEW regulations recognize such discounts and provide for their accountability by the institutional provider of service.

Simply stated, all such discounts must be used to reduce the provider's costs, and, therefore, must accrue ultimately to the benefit of the government. However, where discounts have been used as a competitive device by pharmacists to obtain institutional practice, benefits to the government frequently have been illusory. We know that some pharmacists who purport to grant discounts to obtain nursing home practice have simply inflated their charges so that their net financial position does not change. Any discount is a discount in fact only if the charge being discounted is ascertainable in advance.

At present, approximately 12.5 million prescriptions per year are dispensed to nursing home and extended care facility "in-patients." It is virtually impossible for the government to monitor and audit the reasonableness of charges for this volume of prescriptions. On the other hand, there are only approximately 52,000 pharmacies in this country. We believe that to remedy the situation there should be a general federal requirement that compensation for pharmaceutical services have two components: (1) reimbursement for the cost of the drug; and (2) a specific professional fee for the pharmacist's services. The pharmacist would be required to certify to the government that the fee ultimately charged the government is no greater than the usual and customary fee he charges other parties for the same services. It would be relatively simple to monitor fees based on this method. Cost parameters for drug products could also be established with relative ease. Both items of information are adaptable to computer use, and thus can be utilized to reduce substantially the administrative burdens connected with these programs.

The Kansas Pharmaceutical Association, in cooperation with University of Kansas personnel, and the Kansas Department of Social Welfare have devised a new method of reimbursement for pharmaceutical services in the Kansas Medicaid program.

It will take effect on July 1. APhA believes this unique and workable method will equitably and responsibly serve all drug insurance programs whether government sponsored, as under Title XIX or the envisioned out-of-hospital prescription benefits under Title XVIII, or private insurance programs.

The Kansas Board of Social Welfare, in implementing its Title XIX program in 1967, had committed itself to payment of usual and customary fees, if reasonable, for medical services provided to eligible recipients. While usual, reasonable and customary fee structures were known or ascertainable in other areas of medical services, the Department found itself unable to adopt the method of reimbursing pharmacists at their usual and customary rates because there was no basis for determining the reasonableness of any individual charge. Because

of competitive factors, including antitrust prohibitions, pharmacists were unable even to discuss, much less to standardize, their charges for individual prescriptions. Hence, for the seven years which have ensued since Kansas first adopted a Uniform Welfare Drug Program, reimbursement for pharmaceutical services has been based on a state imposed percentage markup method which bears only occasional relationship to usual and customary charges and no relationship at all to reasonableness from the standpoint of either the pharmacist who provides the service or the state which pays for the service.

Although a flat statewide fee, based upon averages, can be easily administered by a fiscal agent, it may be inequitable because of variables in the number of prescriptions dispensed, overhead expenses and other economic factors. At present, some pharmacies actually subsidize welfare prescription programs at the expense of the general public.

Mr. Chairman, we would like to briefly outline the principles of the new reimbursement method developed in Kansas. This method goes far in providing each pharmacist reasonable reimbursement, while simultaneously providing government simplified pre-audit fiscal controls rather than expensive post-audits which are ineffective in controlling costs.

All pharmacies participating in the Kansas plan will be required to file their average professional fee with the State Welfare Department. The fees will then be ranked from lowest to highest. The highest 10 percent will be reduced automatically to the 90th percentile and no fee paid will exceed this amount. All pharmacies submitting fees will be required to submit financial data to justify the fee filed. Any pharmacy which does not submit a fee will automatically be assigned the lowest fee requested. Fees may be resubmitted annually, or when in the judgment of the Department of Social Welfare, re-evaluation is necessary. The APhA House of Delegates at this year's annual meeting, adopted the following policy: "that the Association vigorously advocate a professional fee system of reimbursement in Medicare-Medicaid and other third-party payment programs which would recognize variations in services provided and costs incurred by individual pharmacists."

We believe that the Kansas plan is equitable to all parties and we recommend that it receive the consideration of this Committee as it studies improvements in the Medicare-Medicaid programs.

Mr. Chairman, we believe that "kickbacks" cannot be entirely eliminated so long as providers compete to serve small hospitals, nursing homes and extended care facilities. However, we believe the Medicare and Medicaid programs encourage the demand and receipt of illegal payment because pharmacists' reimbursement is funneled through these facilities. As we have suggested, we believe that the problem could be controlled further by adding pharmacists to the present list of providers of service under Part A of Medicare and also when out-of-hospital drugs are added to that program. Also, all payments for pharmaceutical services under Medicaid should be required to be made directly to the pharmacist.

We are greatly disturbed that the "kickback" situation we have described exists. Public opinion condemns all such breaches of public trust. However, the most bitter complaints we have received are from pharmacists who have, in fact, been subjected to "kickback" demands. By far the vast majority of the nation's pharmacists conduct themselves with both legal and ethical propriety. Unfortunately, there are some who fail to measure up to their obligations. With assistance from those creating and administering federal programs, we believe that pharmacy can eliminate this unfair competitive practice and devote its best efforts to the primary objective of these programs, providing pharmaceutical services at reasonable cost for persons in need of them.

In this connection, we wish to bring to your attention the results of a research project recently completed by Mr. Jordan Braverman, Research Associate in my office. We are providing copies of his report, "Nursing Home Standards: A Tragic Dilemma In American Health" for the Committee's use. The report goes far beyond the subject of pharmaceutical services and reflects our concern with the entire problem of the delivery of health care services.

The report of your committee staff earlier referred to makes reference, on page 136, to apparent program abuses arising out of physician ownership of facilities. We would like to relate this problem to pharmaceutical services.

Tomorrow morning we are scheduled to appear before the Subcommittee on the Consumer of the Senate Commerce Committee to discuss S, 1575, introduced by Senator Hart. This bill would prohibit federal financial participation in

the cost of drugs or devices under any program where a medical practitioner owns an interest in a drug company or pharmacy or, generally, when he dispenses the drug or device himself.

In stating our full support of S. 1575, we are going to make clear that we do not attribute the abuses the bill would correct or prevent to the vast majority or even the bulk of the medical practitioners in this country. However, there always has been an element in medicine which see financial involvement in the pharmaceutical industry and pharmacy profession as a way of lining its pockets. Senator Hart's prior hearings on physician ownership of pharmacies and manufacturing and repackaging companies, as well as his hearings concerning the dispensing practices of the so-called "fat doctors," have dramatically exposed individual practitioners to public view. Unfortunately, there are always some on whom such lessons have little or no effect. Abuses, both real and potential, continue.

We will submit two recent instances for the record. Appended to our statement is an article which appeared in the Louisville, Kentucky Times on April 16, 1970. The situation described in that article relates to a small Kentucky drug firm, which apparently numbered among its stockholders a substantial number of physicians or members of their immediate families. It illustrates a classic example of the need for legislation restricting physician ownership of health care facilities. While the article speaks for itself, we feel there are several points which should be emphasized. As the Times article points out, so-called "anti-substitution" laws in almost all states prohibit a pharmacist from dispensing the same drug in dosage form manufactured or distributed by a different company if a prescription is written for a particular brand name product. In other words, if a prescription is written for ampicillin under the trade name of one manufacturer, the pharmacist may not legally dispense ampicillin of any other manufacturer.

We seek the repeal of such laws because they represent an unacceptable encroachment on the professional prerogatives of the pharmacist and specifically his unique ability to exercise professional judgments in selection of quality drug products. Antisubstitution laws prohibit most pharmacists from selecting a quality product available at most reasonable cost to the patient and frequently force the pharmacist to dispense a product of lesser quality against his best professional judgment. We point out that the pharmacist is placed on the horns of this dilemma not because he willingly purchases products of lesser quality, but because prescribers are writing prescriptions for them.

We would also point out that the patient often pays a premium for such products, certainly in terms of the price paid in relation to the cost of the product. There can be no question but that the physicians in this situation were given or sold stock to increase sales of the company's brand name products.

Secondly, we would point out that ethical considerations were apparently insufficient to keep the physicians involved with this firm from resisting the temptation of financial gain, even to the point of attempting to disguise their ownership interests by having stock issued in the names of their family members. We know of instances where similar arrangements have been made with regard to pharmacies.

A second situation which we would bring to your attention is described in articles appended to our statement which appeared in the Des Moines, Iowa Tribune on October 23, 1969 and F-D-C Reports ("The Pink Sheet") on May 4, 1970. The staff of the Senate Antitrust Subcommittee is intimately familiar with this situation. It involves Woodland Drug Holding Co., a subsidiary of the Woodland Corporation in which physicians own a very substantial interest. Through Woodland Drug Holding Co., the Woodland Corp. owned three wholesale drug companies in Iowa, a distributor of medical and surgical supplies and equipment, and a pharmacy franchising firm. Although, as the "Pink Sheet" articles describes, the financial fortunes of Woodland Drug Holding Co. have fallen upon hard times, this clearly was not intended. What apparently was intended, and achieved in large part, was control of drug distribution at the wholesale level in Iowa and a substantial interest in drug distribution at the pharmacy level in Iowa and elsewhere.

The Woodland situation makes clear that the physician owners were involved in a substantial conflict of interest in at least the following ways: (1) Physician owners had the incentive to stimulate slow moving drug products in the wholesalers' warehouses by prescribing for them; (2) Physician owners had the incentive to direct patients to Woodland franchised pharmacies paying percentage

fees; (3) Physician owners had the incentive to over-prescribe for their patients, thereby increasing sales by the wholesalers and also increasing the percentage fees received from pharmacy franchises.

In addition to these two specific examples involving abuses related to physician ownership, we can also state that percentage leases of the type that would be prohibited by S. 1575 are in force and continue to be demanded of pharmacists who wish to establish pharmacies in physician-owner medical centers, clinics and even regular commercial buildings.

Section 7 of the American Medical Association's "Principles of Medical Ethics" states specifically: "In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."

It is interesting to note that the Judicial Council of the American Medical Association, even though it would permit physician ownership of pharmacies if patients are not exploited, declares it unethical for a physician to have a financial interest in a drug repackaging company or for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine. The Judicial Council has also stated that physicians should avoid regular dispensing where adequate pharmaceutical services are available and should recognize and promote the practice of pharmacy as a profession and should receive the cooperation of the pharmacist in educating the public concerning the practice of ethical and scientific medicine. Copies of these opinions are appended to our statement for the record. It is apparent that mere ethical pronouncements by the AMA's Judical Council are not and will not be sufficient to remedy the problem we are facing. Legislation is needed.

We emphasize that the failure to legislate with regard to the problem in the drug field has unquestionably, in our view, created the "hands off" climate in which these abuses can flourish in Medicare and Medicaid generally. This failure to legislate has also made possible one of the most indefensible decisions made by government officials in connection with he Medicaid program. The Department of Health, Education, and Welfare's Handbook of Public Assistance Administration entitled "Medical Assistance Programs under Title 19 of the Social Security Act (Supplement-D)" was issued on May 16, 1967. Section D–5150 originally specified that federal financial participation with regard to prescribed drugs:

". . . is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, *where no adequate pharmacy services exist or are available when needed*, and the practitioner dispenses such drugs on his written prescription, and retains records thereof." [Emphasis added.]

On June 28, 1968, the Administrator of HEW's Social and Rehabilitation Service announced a change in this policy which now permits federal financial participation with respect to prescribed drugs in all cases involving physician dispensing:

"Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed, authorized practicitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof."

Since the earlier HEW policy had permitted federal financial participation relating to physician dispensing where adequate pharmaceutical services were not available from licensed pharmacists, it insured that Medicaid patients always would be able to obtain needed medication. What could have influenced responsible HEW officials to relax their stand? In our opinion, it was physician-backed pressures relating not to health care, but to money. The change in HEW policy did absolutely nothing to increase the availability of pharmaceutical services to Medicaid patients.

We are most pleased to see that Section 7 of S. 1575 would reinstate HEW's original policy with regard to federal financial participation in all federally supported programs. This provision is sorely needed to control the escalating costs of these programs by eliminating unwarranted duplication of services.

Finally, Mr. Chairman, rather than discuss only problems experienced by pharmacy in connection with Medicare and Medicaid, we would like to suggest a significant contribution we believe pharmacists could make to these programs and to prepaid prescription benefit programs generally. This contribution relates to the task of drug utilization review, which we believe is a necessary requirement for prepaid prescription programs. A formalized drug utilization review procedure will be necessary to insure that the highest quality health care is being provided patients in relation to program costs. Such a review procedure will also be necessary to control and possibly even reduce program costs.

The Department of Health, Education, and Welfare has recognized the importance of effective utilization review programs. On April 1, 1970, The National Center for Health Services Research and Development published a report entitled, "Drug Utilization and Drug Utilization Review and Control." The author of that study is Dr. Donald C. Brodie, Professor of Pharmacy and Pharmaceutical Chemistry at the School of Pharmacy, University of California, San Francisco Medical Center, San Francisco, California. In his report Dr. Brodie says, "The indispensable component in a national effort to bring about the needed improvement in the distribution and use of drugs is planned and organized study and research."

Mr. Chairman, we concur with that statement. While several research projects are currently being conducted in this area, we emphasize the need for continued and expanded research and development of drug utilization control systems for both the institution and community environments.

We emphasize that the most important aspect of drug utilization review, and the one for which the pharmacist can make the greatest contribution, is in the assurance of rational drug prescribing and dispensing practices. At present, there is great concern among the professions of medicine and pharmacy, as well as among those responsible for the administration of health care programs, about the lack of rational prescribing evident in today's health care system.

The object of rational prescribing is to provide the patient with the right drug in the right amount at the right time. From this definition, and the variables inherent in it, you can see that rational prescribing cannot be expected to flow from inflexible laws, regulations or statements of policy. What is needed is a viable review structure and process which can address itself to particular problems relating to particular drugs, particular diseases and practices. We believe that such a process includes the much discussed concept of "peer review" but goes beyond it, in that it contemplates a multi-disciplinary approach to the problem. It is in this multi-disciplinary context that the pharmacist can and must function if drug utilization review is to achieve its objectives.

Clearly, drug utilization review can be expected to consider program costs and administrative burdens. For many of the problems we anticipate, pharmacists are the best informed, if not the only source of required information. The pharmacy input is necessary, along with input from the other health care professions, consistent with today's increasing "team" approach to health care problems.

We would emphasize that drug utilization review, with the structure and processes we have only briefly outlined, must be required by legislation and not left to voluntary effort. We urge such a requirement, not only because we think it makes good sense, but also for a very practical reason. We fear voluntary efforts toward this end may experience difficulty in mounting effective drug utilization review programs, because of the fear of many professionals that they may be accused of antitrust law violations. Since the drug utilization review process can be expected to result in decisions which may effect the availability and price of drug products, we believe that the entire process will likely be subjected to antitrust scrutiny. Since the objectives of drug utilization review are clearly not anti-competitive, but are designed to insure only high quality health care at reasonable cost, we believe that such efforts should have the specific legislative sanction of Congress.

We expect that it is only a question of time before Congress sees fit to include prescription drugs as a benefit under the Medicare program as is already the case under the Medicaid program. Pharmacy stands ready to make its expertise available to the development and success of such a program and generally to assist you to the full extent of our ability with regard to Medicare and Medicaid.

[From the Louisville Times, Apr. 16, 1970]

KMA Council Urges Doctors to Dispose of Stock in Prospect Drug Firm

(By Wayne Welch)

The young pharmacist, who works in eastern Jefferson County, was furious as he talked to a reporter.

A regular customer had come in a few days before with a prescription to treat a cold.

The drug specified was from a new and little known firm, Bonco Labs, Inc., of Prospect, Ky., a wholesale firm.

The pharmacist, not having the drug on hand, routinely phoned the physician who had written the prescription and asked if he might substitute something

else. (Pharmacists cannot change a prescription without a doctor's permission.)

The doctor became angry, according to the pharmacist, threatened to physically attack the pharmacist, and said he'd find a place to get the prescription filled as written.

The patient wound up waiting two days for his medicine, the pharmacist noted.

"I have nothing against the drug,' the pharmacist said, "but this is no way for professionals to treat each other."

He indicated there must be some special reason why the physician was so insistent on the Bonco drug.

KMA STEPS IN

The Judicial Council of the Kentucky Medical Association (KMA), after some investigating, announced yesterday it "strongly urges" all physicians who own stock in Bonco to dispose of it. This "urging" extended to stock owned by members of a physician's family.

The KMA council admitted it doesn't know how many physicians actually own stock, and Thomas Bond Jr., president of Bonco, would not say. Talks with some pharmacists indicated it might be 50 to 100, apparently including some doctors in Southern Indiana.

The problem in the past several weeks has come to the attention of medical and pharmaceutical professional organizations concerned with the possibility that some doctors might be changing their prescription-writing habits to help boost their Bonco stock.

Investigations into Bonco already had been held by the Jefferson County Academy of Pharmacy and the Jefferson County Medical Society before the KMA got involved.

FIRM'S LEGALITY NOT QUESTIONED

Dr. N. Lewis Bosworth of Lexington, chairman of the five-member KMA Judicial Council, said there is nothing illegal about the Bonco type of firm.

"It is just unethical for a doctor," he said, referring to a policy of the American Medical Association (AMA) and its affiliate groups against doctors having a financial interest in a drug firm.

The medical societies, increasingly sensitive to public criticism of doctor's finances, apparently have moved swiftly to meet a problem they find sensitive and potentially embarassing.

The KMA Judicial Council, which ordinarily meets quarterly, has had at least one special meeting on Bonco, and quickly drew up the statement announced yesterday.

The statement is to be read at the next meeting of all county medical societies in Kentucky.

Throughout the talks, no one—not even a few irate pharmacists who talked to a reporter—has questioned the quality of Bonco drugs.

Officers of Bonco, which is incorporated in Delaware, are Thomas Bond Jr., Ronald R. Cox, vice-president and secretary; and James E. Bond, treasurer. The name, Bonco, apparently comes from a combination of Bond and Cox.

The firm markets under its own label drugs produced by generic drug makers.

Bond, who indicated he might have a statement later on the KMA action, indicated the firm hopes to expand and produce its own drugs.

Bosworth said Bond was invited to talk with the council, but preferred not to come.

Bond disputed this today, saying he told the council he could not come "at that particular time." Bond said he invited the council to visit Bonco, but was told the council members were very busy and couldn't.

"I don't think their time is any more valuable than mine." Bond said.

An early rumor among pharmacists was that Bonco, apparently aware of the AMA directive about direct physician ownership of drug stock they can influence, had offered to stock physicians' wives.

Bosworth confirmed this to some degree, noting that wives did own stock. In one case it was a daughter, about 22 year old, he said.

"Our concern," the KMA statement says, "lies with the temptation which is bound to be present on the part of a physician-stockholder to prescribe Bonco products in order to further his financial interest (or that of his family) in the company."

The statement said all physicians interviewed by the Judicial Council—eight to 10 were called in—were aware it is unethical for a physician to own stock in a drug-repackaging house.

Each physician was emphatic that Banco is not a repackaging house, the council asserts, but "we are not so sure."

Even if Bonco is not a repackaging firm, the council says, the fact that doctors could help boost stock of a small drug company by writing prescriptions could hardly escape the attention of the company.

The council, as does the AMA, drew a distinction between the Bonco case and that of a doctor owning stock in a large national drug firm like Lilly or Abbott.

The council said a single doctor or even several would have no notable effect on a large company by writing prescriptions specifying their products.

Bond did say this was discrimination against small firms. "All of these companies that are major manufacturers today didn't start out big."

The KMA Judicial Council said no disciplinary action is planned against physicians who own stock in Bonco.

One council member indicated, however, there would be checks later to see if physicians actually did dispose of Bonco stock.

[From the Des Moines (Iowa) Tribune, Oct. 23, 1969]

Probe Doctor-Drugs Tie

Involvement in wholesale, retail sales studied—Woodland Corp. data subpoenaed

(By George Anthan)

Involvement of a group of Des Moines and central Iowa medical doctors in the wholesale and retail sale of drugs is being investigated by the U.S. Senate's subcommittee on antitrust and monopoly.

A subcommittee official told The Tribune by telephone from Washington, D.C., Thursday that the object of the investigation is the Woodland Corp. of Des Moines. The firm's records have been subpoenaed by the subcommittee, the official said.

Woodland Corp. officials have reported that medical doctors own a large percentage of the stock in the firm.

Two wholesale houses

Woodland Corp. now owns and operates two major drug wholesale houses, Des Moines Drug Co. and Iowa Drug Co., believed to be the largest independent drug wholesalers in the state.

Woodland officials also have said the firm is involved in the retail drugstore franchise business.

Dorothy Goodwin, assistant counsel for the anti-trust and monopoly subcommittee, said the investigation is aimed at setting up hearings in connection with a bill that would prohibit doctors from selling drugs, except under rare circumstances.

The bill, sponsored by Senator Philip Hart (Dem., Mich.), the subcommittee chairman, currently is pending before the Senate Commerce Committee.

"It is my feeling this bill is aimed at the type of practices (involving drug sales) that the Iowa doctors say they are involved in," Miss Goodwin said.

The measure would, she said, prohibit doctors from selling drugs either at wholesale or retail, except in certain rural areas where there was no other supply of medicines.

Interviews here

Miss Goodwin was in Des Moines for several days about two weeks ago, interviewing Woodland officials and gathering information about the firm's activities.

She also met with Robert Gibbs, executive secretary of the Iowa Pharmaceutical Association, who has declared:

"I do not understand why doctors want to invest their money in such fields as drug manufacture and distribution . . . when there are so many other places for them to put their money."

He supports the proposed federal legislation, saying the American Medical Association "has failed to recognize the problem of physician conflict of interest."

Many independent pharmacists in Des Moines and central Iowa have strongly opposed the involvement of doctors in the drug business, especially in the franchising of retail drug stores.

Miss Goodwin said her probe of Woodland's operations "certainly raises questions" about the possibility of conflict of interest on the part of doctor-stockholders.

She said doctor-involvement in Woodland Corp. could make it possible for physician-stockholders to profit from drugs they prescribe to their patients, although she emphasized there is no evidence to indicate this is happening.

But if physician-stockholders did profit from drugs they prescribed to their patients, "that certainly is not right," Miss Goodwin said.

"NOT SURPRISED"

Harold Castle of Des Moines, Woodland Corp. president, said Thursday that "I would not be surprised" if Woodland is included in U. S. Senate hearings into the selling of drugs by doctors.

Castle said a recent check indicated that doctors own some 400,000 shares of Woodland stock, out of a total of 836,000 shares outstanding.

There are four medical doctors on Woodland's nine-member board of directors. Two other doctors resigned from the board earlier this year.

Castle said Woodland Corp. is negotiating to acquire P.D.Q. of America, Inc., which has several franchised drugstores in the Des Moines area, and whose officials have stated will be expanded into a national chain. P.D.Q. of America, Inc., has offices at Des Moines Drug Co., 2511 Bell ave.

LETTER

However, present relationship between Woodland and P.D.Q. of America, Inc., is not entirely clear because Dr. John Gustafson, chairman of Woodland Corp., reported in a letter published in the May-June issue of The Bulletin of the Polk County Medical Society that Woodland "acquired, effective Jan. 1, 1969, the P.D.Q. franchise operation."

Gustafson stated in an interview last summer, "There is no question about it. We have acquired P.D.Q. and we are working together and have been since Jan. 1."

Many independent druggists in Des Moines and throughout the state reportedly have severely limited their purchases from Iowa and Des Moines Drug Companies, contending that entry of Woodland Corp. into the retail drug business as well as the wholesale drug business would give doctors too much financial interest in the sale of drugs.

Senator Hart's bill also would prohibit doctors from owning and operating drug repackaging firms.

[From the FDC Reports, "The Pink Sheet," May 4, 1970]

DRUGGISTS BOYCOTT OF DES MOINES WHOLESALE DRUG LEADS TO BANKRUPTCY: FATE OF PDQ RETAIL DRUG FRANCHISING OPERATIONS LIES WITH TRUSTEES

A partial boycott of Des Moines Drug Co. by "large numbers of its regular retail drugstore customers," was a major factor in the 73-year-old, full-line whsle. drug firm's recent filing under Chapter 11 of the bankruptcy act.

The move had been expected since early this year when parent corp. Woodland Drug Holding Co. announced that unless it could find a buyer soon, Des Moines Whsle. would be "incapable of continuing in business more than a short time."

Woodland said the "sudden refusal" by these customers to purchase from Des Moines Drug, "or the lessening of such purchases," was brought on by extensive newspaper publicity about Woodland's MD ownership and Des Moines Whsle.'s "working relationship" with PDQ of America, a retail drug franchise business which Woodland took effective control of in mid-1969.

Following the publicity, sales of Des Moines Drug—an NWDA member—declined from $750,000 per month ($9 mil. annually) to as low as $200,000 per month, Woodland said. When Woodland bought the whslr. in Nov. 1966, it was the largest independent drug whslr. in Iowa, with sales in the $5 mil. range. Iowa pharmacy leaders said disenchantment with Des Moines Drug stemmed equally from the firm's cutback both in products and services following its purchase by Woodland.

IOWA WHOLESALE DRUG, DEFUNCT AFTER 42 YEARS IN BUSINESS, TWO WITH WOODLAND

Woodland Drug Holding—also now in bankruptcy—is a 92.5%-owned subsidiary of Woodland Corp., a large MD-controlled holding company with interests in real estate development, banks, franchised Holiday Inns and movie houses. The MD control of Woodland Corp. was the spark which touched off the publicity, which in turn prompted an investigation by Sen. Hart's (D-Mich.) antitrust subcmte.

"Repeated newspaper and TV publicity and Congressional activity," which challenged the "ethics and proprietary" of the MD control—"allegedly allowing physicians to profit indirectly from the whsle. and retail distribution of Rx drugs"—was a major contributing factor to Des Moines Drug's financial plight, Woodland said.

Woodland Corp. said it has been attempting for over a year to sell its interest in Woodland Drug Holding—or presumably any of its subsidiaries individually. Besides Des Moines Drug, the holding company controls by various means:

Iowa Whsle. Drug—Now-defunct Des Moines whslr.. 87%-owned by Woodland since Oct. 1967. According to Woodland, Iowa Whsle. was facing immediate bankruptcy when it bought the firm, and had been offered for sale repeatedly. Woodland's efforts to revive Iowa Whsle. were described as "too little and too late" and its operations were shut down in the summer of 1969. The company is "beyond rehabilitation" and "should be liquidated," Woodland said.

Iowa Whsle., formed in 1928, had sales ranging from $3.5 mil. to $4.7 mil. annually over a ten-year period up to 1965, with small profits and losses. In 1966 it lost $192,804 and has continued to lose money ever since, according to Woodland, which blamed the firm's problems "in general" on "the market effect of changes in the independent drug whsle. field, as well as lax management practices." The firm had been controlled by the F. W. Fitch family.

Capitol City Whsle. Drug—Mail-order discount whslr., serving a five-state area, formed by Woodland in April 1968. Sales in the first partial year were under $200,000 and expanded to about $2 mil. in the FY to July 31, 1969. Capitol employees fill orders at night from Des Moines Drug's inventory. It could not be sold or operated apart from Des Moines and therefore is "subject to the same adverse financial influences," Woodland said.

Standard Medical & Surgical Supply—65-year-old Des Moines distributor of medical and surgical supplies and equipment, also now in bankruptcy. Woodland gained control of Standard through a complicated series of financial transactions in 1967 and 1968 involving two holding companies owned by Woodland Corp. Chairman John Gustafson.

Woodland said that through the FY ended April 30, 1965, Standard experienced "modest but steady net profits from operations and a gradually expanding sales volume." However, in each of the subsequent years it lost money on declining sales.

Among the reasons for Standard's problems are the write-off of about $64,000 in FY 1966 of an investment in a wholly-owned subsidiary, which became insolvent, and installment payments on judgments against it of about $63,000 from two lawsuits, Woodland said.

PDQ of America—A drug store franchise operation which admitted four Woodland execs to its eight-man board in 1969 after it was unable to pay Des Moines and Iowa Whsle. for merchandise provided during PDQ's 1968 formation. Extent of the debt is highlighted by a now-cancelled agreement which would have given Woodland a 67% equity interest in PDQ as partial settlement.

WOODLAND VIVIDLY DESCRIBES DEMISE OF DES MOINES DRUG FOLLOWING MERGER

PDQ was formed to develop and sell a franchised program for independent druggists. Its first—and still the only—franchisee was Drug Mart Inc., a group of six formerly independent drug stores that united in 1968.

Drug Mart also is heavily in debt to Des Moines Drug for merchandise acquired in 1968. Woodland's equity interest in Drug Mart would have been 75% under the proposed settlement.

Early this year Drug Mart operated 13 PDQ franchise stores, nine in Des Moines, one each in Waterloo and Fort Dodge, Iowa; Lincoln, Neb., and St. Joseph, Mo. PDQ also operated an outlet under its name in Colorado Springs, Colo. It is understood, however, that a number of these outlets since have been closed, including those in Waterloo and Fort Dodge.

In June 1969, PDQ hired Franchises Internatl. (F–I) to establish a nationwide marketing program for PDQ franchises, but marketing plans never got off the ground because PDQ could not meet certain financial requirements or hire the necessary people. PDQ has paid F–I $50,000 and is required to issue to it 58,275 (7½%) of its stock.

Attempts were made to convert PDQ's debt to equity via a program recommended by F–I, in an effort to qualify PDQ for a Small Business Administration loan, and thus allow F–I to go ahead with its marketing plans. Such action ended when Woodland Drug Holding filed bankruptcy, and the fate of PDQ now rests largely in the hands of Woodland's receivers.

Woodland's own description of Des Moines Drug's demise reads like the "Problem" section of a business school case study. Woodland said prior to its acquisition, Des Moines Whsle. "had been managed conservatively by the same management for many years. It had been continuously profitable, although the return on its capital investment was modest."

Following the purchase "it continue under the same active management for about a year. Eventually, the then president and a number of other management personnel left or were discharged. Continuous problems of maintaining and controlling inventory were experienced," Woodland said.

"Heavy interest charges were required to meet purchase money indebtedness. Gradually sales declined, margins worsened, and operating expenses increased. Large amounts of inventory were found to be unsalable or excessive and were disposed of in bulk at distress prices or were written down in value on the books," Woodland added.

"Credit was extended without sufficient controls with substantial bad debt experiences. Working capital, the essence of a whsle. operation, became depleted. Maximum loans were obtained, but were still not sufficient." Woodland continued. In the FYs ended July 31, 1968 and 1969 and subsequent interim period, Des Moines Drug sustained "large operating losses."

Besides the publicity regarding Woodland's MD ownership and Des Moines Drug's ties with PDQ, Woodland blamed the whslr.'s problems on "the general decline in numbers and financial health of the independent retail pharmacies which are the firm's principal customers," and "increasing competition of discount stores and natl. and local chain drug outlets."

Woodland said that because of Des Moines Drug's deteriorated credit standing, most suppliers now demand cash with orders, adding that the company can no longer supply many items typically ordered from a whsle. drug company.

EX-WOODLAND PRESIDENT LOUIS MULLER'S REORGANIZATION EFFORT FAILED

J. W. Edgerly, 101-year-old full-line whslr. headquartered in Ottumwa, Iowa, has been the principal force moving into the Des Moines market to fill the void being left by Des Moines Drug. In May 1968 Edgerly bought the inventory of Cramer Drug in Des Moines.

Cramer was doing about $465,000 a year volume at that time. Edgerly's big push came last fall, however, when it opened a branch in Adel, right outside Des Moines.

Drug whslrs. outside the Des Moines area also have begun filling orders in the city—including McKesson, which has houses in Burlington, Cedar Rapids and Sioux City, Morphy Drug in Council Bluffs and Torbert Drug in Debuque.

Rumors have been circulating that Chicago-based whslr. Louis Zahn is eyeing the Des Moines market, but insiders say if the company hasn't moved by now it probably won't. Zahn had planned in January to buy Des Moines Drug, but decided against the move.

Woodland Drug Holding's former President Louis Muller had attempted to organize a group of the company's employees and other investors to buy the operation, but this too fell through as a result of the bankruptcy proceeding.

Muller had indicated that he was not interested in the PDQ operation. "The doctors took a beating on this," Muller was quoted as telling the Des Moines Tribune. "Otherwise the employees could never have come up with the money" to buy the firm.

Muller had been president of Woodland Drug Holding—and all its subsidiaries—since the fall of 1967. For one year before that he was sales manager for Abco Dealers Inc., a NY co-op group of mfrs.' representatives for surgical supply companies. From 1964 to 1966 he was a sales manager with J&J.

GILPIN SET TO LAUNCH STORE-LEVEL COMPUTER ORDERING SYSTEM FOR RETAIL AND HOSPITAL CUSTOMERS; TERMINALS ALSO WILL HANDLE THIRD-PARTY CLAIMS

DC-based whslr. Henry Gilpin is on the brink of launching a fully computerized Rx ordering system designed to speed deliveries, cut pharmacists' paperwork *and electronically transmit third-party Rx claims for processing.* Gilpin has been quietly working the bugs out of the system in a one-pharmacy test since December, and is expected to expand operations to several other sites in a few weeks.

The system, called Rx-Econ, provides a direct hook-up between pharmacies and Gilpin's central computers via in-store electronic ordering terminals. The terminals, small enough to fit on a counter-top, are geared to virtually eliminate ordering paperwork and speed deliveries to one day.

Other whslrs., notably McKesson & Robins through its Economost program, have also been developing direct computer links with pharmacies, but Gilpin's systems is believed to be the first effort to provide all customers with store-level terminals.

Gilpin forecasts "a fairly good size" Rx-Econ system in operation within six to 12 months, depending on the availability of low-cost terminals. Terminals compatible with the system now rent for about $140 per month, but the whslr. expects rates to drop to $50 soon. Pharmacies using Rx-Econ will be charged a yet-unannounced fee based on terminal use and the amount of central services provided.

The whslr. will offer Rx-Econ to all of its customers, retailers and hospitals as well as its Sentry pharmacy franchises. In addition to handling orders, the system provides a basic facility which eventually will be expanded to offer pharmacies electronic accounting services such as computerized family record systems, instant drug interaction data and centralized charge account record-keeping, Gilpin said.

START-UP COSTS OF SENTRY AND CARE FRANCHISE PROGRAMS HURT GILPIN'S PROFITS

Rx-Econ is programmed to accept only Rx orders, but could be broadened to include proprietaries and front-end merchandise as well, company officials said. Gilpin handles housewares, toys, notions and other sundries through its recently-acquired Point-of-Purchase rack-jobber subsidiary.

The advantages of computerized ordering, however, may be overshadowed by the system's potential applications in the third-party area. Using Rx-Econ, pharmacies will transmit claim data daily to Gilpin via the terminals, eliminating the need for claim forms except for store-level record-keeping. Gilpin then will channel this data, already translated into computer "language," to third parties for fast reimbursement.

The whslr. installed new IBM 1130 computers in each of its four whsle. drug divs. last year, a move which contributed to Gilpin's depressed 1969 earnings. Net dropped 28% from $278,000 in 1968 to $200,000 in 1969. Sales increased 4.4% to $33.5 mil., from $32.1 mil. in 1968.

Other factors adversely affecting 1969 profits were higher interest rates and operating expenses, lower gross profit margins, start-up costs of Gilpin's Sentry and Care drug store franchise systems and expenses incurred due to acquisitions. The company said its Chem-O-Seal institutional housekeeping service business was "unprofitable in terms of the time and management talent required for its administration," and announced plans to dispose of the two-year-old subsidiary. Gilpin's wholly-owned McKenna Surgical Supply subsidiary, however, is "progressing profitably" with over 80% of its volume stemming from sales to hospitals, the company said. Gilpin's acquired the $1.5 mil.-sales Va.-based supplier in Jan. 1969.

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL

(Prepared and Approved by the Judicial Council, American Medical Association)

41. Physician ownership of drugstores, drug prepackaging houses and pharmaceutical companies and dispensing of glasses by physicians

Section 7 of the Principles of Medical Ethics provides: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to have a financial interest in a drug repackaging company.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

These practices are contrary to the best interest of the public and the medical profession.

The Council calls the attention of the House to the following statement concerning the meaning of the words "drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient" which was adopted by the Council on June 26, 1958.

It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient"; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

48. Dispensing drugs

Although there are circumstances in which physicians may ethically engage in the dispensing of drugs, the American Medical Association nevertheless urges physicians to avoid the regular dispensing and the retail sale of drugs to patients wherever the drug needs of patients can be met adequately by local ethical pharmacies.

49. Definition of a drug repackaging company

The term "repackaging company" as used by the Judicial Council and approved by the House of Delegates refers to a drug company which markets under its own label or trade names drug products manufactured by others with the objective that physicians having a financial interest in the drug company will prescribe its drugs to the patient.

PRESCRIPTION CENTER, INC.,
Topeka, Kans., June 2, 1970.

AMERICAN PHARMACEUTICAL ASSOCIATION,
Washington, D.C.

GENTLEMEN: I am returning and thanking you for the use of the film strip and recording on pharmaceutical service in the nursing home. This is a very good production and should be useful to some people I suppose. I found it to be of no help to me. I have just lost the nursing home that I have been the consultant for, for the last 6 years since I will not pay a 15% kickback as I was told I must by the Minister who is the administrator of this church owned home. I am finding out much to my dismay that Pharmacy might be a profession, but there are a very few if any professionals in it. We have 2 large homes in our town that are completely sewed up by an ex-member of our state board of pharmacy through a percentage kickback arrangement. Nice deal huh? I am 35 years old, out of Pharmacy School for 14 years and have owned by own professional shop for 8 years and I believe the longhaired kids are about right. The establishment is a bunch of crap. Professionalism will never get off the ground in Pharmacy as long as we have to put up with the dollar hoos, discount merchants, and hipocracy that we have in this town and state.

J. A. MATCHETT.

"GUARDIANS OF YOUR HEALTH,"
April 17, 1970.

Dr. WILLIAM S. APPLE,
American Pharmaceutical Association,
Washington, D.C.

DEAR BILL: I called last week to ask you a question, not realizing that the Convention was in session, and decided to write you rather than disturb you there.

There are, currently, two nursing homes in both of whom

allow their patients the freedom of choice of pharmacies. One of the homes is sponsored by the which is a local organization, devoted to maintaining this home for the elderly, and has a wealthier clientle than most nursing homes in this area. Many of the people in this home are well and ambulatory, and so our prescription volume is not great there, although I imagine we dispense anywhere from 20 to 35 prescriptions a week on a twice-weekly delivery order. The other nursing home is somewhat larger, and I believe we probably have 95% of the business there. This was built by local people, who had no knowledge of the operation of a nursing home. They, currently, have a professional, who has just been hired to come here and manage the home, and he has posed a question to me that I do not feel I can properly answer.

As I stated before, the patients, or their families, have free choice of pharmacies, and again, we probably have 95% of the business in that home. The new director has been told, by Social Welfare and Medicare people, that it would be best if the nursing home chose one pharmacy to supply all of their patients with their pharmaceutical needs. He would like to do this, because it really would make his billing procedures a little more simple. Many of the people at his home are receiving some type of aid, where the government, the state, or some welfare association pays a certain amount of the drugs, and the family, or someone else, has to pay the rest. He has, therefore, approached me with the idea of our billing the home for all of the prescriptions delivered, during the month. Of course, in the back of his mind is the idea that we will pay him to collect the bills for us.

This new administrator, by the way, is not looking for a kickback, as he formerly worked in a home in the outskirts of Philadelphia, that was owned by physicians who had a 20% kickback with the local pharmacy. He found this to be, not only distasteful but the pharmacy that was providing the service was not doing a proper job, and made many, very serious errors in the dispensing of prescription, but in this case, his hands were tied. What he is looking for is a cash discount. I do feel that it is quite in order for me to participate in this manner. because he would be paying me promptly each month for the accounts of ninety-five people, some of whom do not pay me, not only monthly, but wait four, five, or six months. It would save me a good deal of trouble to send one stantement, instead of ninety-five, and of course, would greatly help my cash flow, to be promptly paid.

Now for the question that I would like your advice in answering. What kind of a discount, or cash, should I offer him? In my own business, of course, 2% is about the most anyone gives me, for paying cash, but the situation is not analagous to any I have run across, and I would like your advice, because I, of course, want to maintain my relationship with this home on a highly ethical plane.

I might add that the director of this home is an ordained Presbyterian minister, and he and I became good friends on his arrival in because we are fellow Rotarians, and our relationship is an exceptionally good one, at present.

Our oldest son has been accepted at the American University in Washington, D.C. and, when we take him there, or at least sometime in the very near future, I am sure we will be there, and I hope we will have the opportunity to have lunch together. Best regards.

Yours very truly,

COMMUNITY DRUG STORES, INC.

AMERICAN PHARMACEUTICAL ASSOCIATION,
THE NATIONAL PROFESSIONAL SOCIETY OF PHARMACISTS,
June 30, 1970.

Hon. CLINTON P. ANDERSON.
Chairman, Subcommittee on Medicare and Medicaid,
U.S. Senate, Washington, D.C.

DEAR SENATOR ANDERSON: We wish to supplement our recent testimony before your Subcommittee on Medicare and Medicaid by submitting for the record this letter and the article from the trade publication *Modern Nursing Home* attached hereto.

The attached article by Attorney Melvin O. Moehle discusses the subject of pharmacy discounts to nursing homes, including the distinction between legitimate discounts and illegal "kickbacks." Mr. Moehle suggests that a nursing home is entitled to charge a pharmacist for services provided by the nursing home which benefit the pharmacist's practice. He further suggests that such arrangements should be the subject of specific agreement between the nursing home and the pharmacist involved.

Generally, we concur in Mr. Moehle's views and, as we indicated in our statement to the Subcommittee, recognize a distinction between legitimate discounts and payment for services rendered to the pharmacist on the one hand, and "under-the-table" payments demanded and paid to obtain nursing home practice on the other. However, we do take strenuous exception to one aspect of Mr. Moehle's thesis and we ask you to consider both his views and ours in relation to the problems we discussed during our appearance before the Subcommittee.

Mr. Moehle sugests that for "bookkeeping service and collection guarantee the pharmacy pays the nursing home a percentage (usually 15 to 25 percent) which is ordinarily a 'deduction' from the total bill."

Mr. Moehle's percentage rate suggestion illustrates our contention that pharmacists are required "to pay through the nose" to obtain nursing home practice. Economic data from the 1968 edition of the well recognized *Lilly Digest* shows that for pharmacies whose prescription income represents 45 to 50 percent of sales, net profit is only 5.0 percent. This net profit is a residue of gross income after deducting cost of goods sold (62.9 percent) and costs of operation (32.1 percent). For pharmacies whose prescription income represents 60 to 75 percent of sales, net profit is only 5.9 percent. In this category, cost of goods sold is slightly lower (61.0 percent) while cost of operation is slightly higher (33.1 percent).

Commercial charge account services, which provide pharmacists with the same services Mr. Moehle discusses when provided by nursing homes, charge the pharmacist only from 7 to 12 percent of gross income. These commercial charge services realize what they regard as a reasonable profit from their services and charges. Nursing homes are ostensibly in the business of providing health care, not billing and guarantee services for their supliers. Pharmacists and other suppliers to nursing homes should not be required to reimburse nursing homes and related faciilties for more than the reasonable costs of the services they are provided by the facility. Certainly, a flat percentage payment unrelated to cost and ranging from 15 to 25 percent is both exorbitant and unconscionable.

Sincerely,

WILLIAM S. APPLE.

Enclosure.

[From the Modern Nursing Home, June 1970]

PHARMACY DISCOUNTS: ILLEGAL? UNETHICAL? DISHONEST?

IF LEGIMATE SERVICE IS PROVIDED, PROPER ACCOUNTING PROCEDURES ARE USED, AND THESE GUIDELINES ARE FOLLOWED, PHARMACY DISCOUNTS SHOULD NOT BE MISUNDERSTOOD

(By Melvin O. Moehle)

If someone else keeps the pharmacists' books on 50 accounts, so he need keep but one—how much is that worth to him?

If payment is guaranteed with 30 days—what is that worth?

If someone else must make the collections and the pharmacist has already banked the check—how much is that worth?

If someone else takes the loss on unpaid bills—how much should the pharmacist pay for that service?

There are some who insist that these services be rendered by the nursing home free of charge. They use words like "kickback" or "coerced discounts" to describe the deduction given a nursing home or ECF for volume purchasing. In many situations it is unfair to put the same label on all nursing-pharmacy transactions.

This is not to say that there are not cases where kickbacks occur. Where the dollar goes in some individual's pocket for business favors given rather than to offset the legitimate cost of a business expense, it is a kickback. The practice of adding to the normal or regular over-the-counter price and then giving a discount is unethical.

Instead of labeling all nursing home-pharmacy transactions as kickbacks and insisting that homes or extended care facilities provide these bookkeeping functions with no offsetting income, rules should be made, with the supplying pharmacy establishing the following points:

1. The pharmacy (or group of pharmacies in some type of rotation) supplies the nursing home with drugs and sends a bill, itemized by patient name, to the facility when the drugs are delivered.

2. The price of prescriptions is the pharmacy's regular price, that price for which the same prescriptions could be purchased by an individual over the counter from that pharmacy.

3. When the prescriptions are delivered, the bookkeeping department of the nursing home posts the charge to the individual patient's account for billing at the end of the month.

4. The nursing home pays the pharmacy at the end of the month for all drugs received that month, without deduction for unpaid bills.

It is recommended that the details of any such agreement be in writing, but if they are not in writing they should be agreed to in advance by the pharmacy and the nursing home.

This procedure enables the pharmacy to carry one account instead of 50 to 100 without the responsibility of billing or collection, with the attendant risks of collection losses. For the bookkeeping service and collection guarantee the pharmacy pays the nursing home a percentage (usually 15 to 25 percent) which is ordinarily a "deduction" from the total bill. Sometimes the pharmacist serves as a consultant to the nursing home in consideration for some of the volume of business. This method pays the nursing home—not the owner or administor—for its services and collecting guarantee. The income is handled the same as any other income from services rendered.

To blanket all pharmacy discounts as kickbacks is unfair and ignores the practice of granting discounts by both government and industry. Discounts on food, furniture and supplies are recognized as legitimate and are practiced every day by most commercial establishments in the United States, including both state and federal governments.

If a legitimate service is provided and proper accounting procedures are used, then the use of pharmacy discounts should not be considered illegal, unethical or dishonest. If the guidelines established here are followed, there need be no misunderstanding of what is meant when someonet mentions pharmacy discounts.

Senator Anderson. The American Dental Association.

STATEMENT OF DR. FLOYD E. DEWHIRST, MEMBER, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER, AND HAL M. CHRISTENSEN, DIRECTOR, WASHINGTON OFFICE, AMERICAN DENTAL ASSOCIATION

Dr. Dewhirst. Mr. Chairman, members of the committee, my name is Dr. Floyd E. Dewhirst of Los Angeles. In addition to maintaining a private dental practice in that city, I am a member of the Council on Legislation of the American Dental Association, the organization I represent here this morning. With me are Mr. Bernard J. Conway of Chicago, chief legal officer of the association, and Mr. Hal M. Christensen, director of the association's Washington office.

We welcome this opportunity to discuss medicaid with the committee. We offer, as we have in the past our wholehearted cooperation in working toward a program that is both professionally and financially sound.

The American Dental Association supported the 1965 enactment of medicaid as, in previous years, we had supported similar legislative proposals.

Health care is an empty right unless mechanisms exist assuring all citizens of ready and continuing access to high-quality care. Government on all levels has an appropriate role to play in supporting such mechanisms as may be needed.

Medicaid, in its present form, may not necessarily be the ultimate mechanism of choice. Whatever the program, however, its dental as-

pects will be truly effective only if there is a basic rethinking, especially at the Federal level, of the proper way to combat dental disease.

Much of the controversy over medicaid in recent months has been, we think, misdirected. This is unfortunate not because some of the criticism has reflected unfairly on some participants, though this has happened, but because it has obscured the nature of the medicaid dilemma. Much of the public criticism leveled against medicaid has equally good case, perhaps a better one could be founded on the premise that medicaid has been underfunded. Certainly this is true with respect to dental care, since only a few States provide anything approaching adequate dental benefits. Thousands of words have been spread over the front pages of the Nation's newspapers telling about the cost of medicaid; too few words have been written about the amount of care it has made possible for people in need, care they would probably not have received had it not been for medicaid.

Annual dental spending under medicaid is estimated to total some $210 million. This amounts to about 5 percent of the medicaid dollar. Some 80 percent of medicaid's dental spending is concentrated in three States: New York, California, and Massachusetts. This is true essentially for two reasons: only a handful of States offer relatively comprehensive dental benefits, and, of them, only these three have been able, or willing, to allocate the necessary matching money.

When medicaid was being first considered in 1965, the association was concerned that not everyone involved understood what the potential cost of the dental segment might be. Dental disease is endemic in the United States, as it is throughout most of the world. It is a rare person who does not suffer from some manifestation of it. The dental disease backlog in the country is appallingly large. Especially relevant to a program like medicaid is the fact that those with less education and more modest incomes are the least likely to have had continuing dental care.

Private sector expenditures for dental care currently amount to some $4 billion a year. It is generally agreed that this represents continuing and relatively comprehensive dental care for less than half the population. The dollar dimensions, then, of rapidly extending such care to everyone are considerable.

For both professional and financial reasons, the association has for more than 30 years been urging that dental care in this country be focused on preventive services for children. If one generation of children could be brought to adulthood while enjoying sound oral health, it would provide the most realistic path toward genuine control of our dental disease problem.

During the original consideration of medicaid, Senator Abraham A. Ribicoff, in consultation with the association, offered an amendment to medicaid that took these considerations into account. The Ribicoff amendment would have required States to build their medicaid dental care programs around preventive services for children. This committee accepted the amendment; so did the entire Senate. It was eliminated from the bill, however, during the subsequent Senate-House conference.

We think the amendment made sense then; we think it still makes sense. Of the $210 million or so being now paid under medicaid for dental care, a significant percentage goes to repair damage that wouldn't have occurred if a sound children's program had existed.

Such funds will continue to be misdirected until a sound children's program is begun.

In this same vein, we would like to call attention to another program approved by this committee and, in this case, enacted in 1967. This is section 510, title V of the Social Security Act. It authorizes a series of dental care pilot projects for needy children that would have a two-fold purpose. One would be to give care. A second purpose, of perhaps more long-range importance, would be to experiment with various mechanisms within differing settings for delivery of that care, in the search to identify those alternatives that have the most promise. The law has been in existence since the middle of fiscal 1968 but the projects have never been inaugurated. Had they begun immediately, we would new be well ahead in knowing just how to mount a sound dental program for all children. The failure to provide funds for this program is, in our opinion, one more example of the disordered priorities in dental care that have become embedded in the Federal administrative process. We are strongly supporting funding of section 510, title V for fiscal 1971 even though, once again, the administration has not requested funds for its implementation. In our opinion, $5 to $7 million should be allocated to it in the coming year, a sum that is less than 5 percent of the dental care spending under medicaid.

There have been few depth analyses made thus far of medicaid's dental expenditures. Two studies that have been completed, however, do much to confirm the value of focusing on preventive services for children. Both concern counties of upper New York State, a jurisdiction that accounts for about half of all dental funds spent under authority of title XIX.[1]

We have submitted to the committee staff a copy of the more extensive of these two studies. We would like, however, to note here a few of the highlights of both:

> Prior to medicaid's inception, one county studied was spending about $130,000 a year for dental care services and the other about $10,000 a year. Since Medicaid, this has moved upward to nearly $2 million a year in the first county and some $500,000 a year in the other. In neither county has there been full utilization of the benefits by all those eligible. The backlog of need is indeed appallingly large.
>
> In one study, more than two-thirds of the bills charged for services rendered to a patient were under $50. Only 18 percent of the bills in the other study were for more than $100.
>
> Both studies show a distinct age-cost relationship. In one study, more than half the bills for children under 5 years of age were for less than $20. In the other study, patients under 25 years of age constituted 79 percent of the total population surveyed but accounted for only 48 percent of the total cost while those over 55 years of age were only 8 percent of the sample but accounted for 21 percent of the expense.

[1] One study was by Drs. Robert M. O'Shea and G. Donald Bissell of the Erie County Department of Health and School of Dentistry, State University of New York, Buffalo, and is reported in "Public Health Reports," vol. 84, No. 3, March 1969, pp. 241–242. The second, more extensive study is an Analysis of the Title XIX Dental Care Program in Chemung County, New York, July 1, 1967–June 30, 1968, by Robert C. Faine, DDS., M.P.H., resident in dental public health, Community Programs Branch, Division of Dental Health, Bureau of Health, Professions Education and Manpower Training, National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare, 75 pp.

In one study, dentures accounted for less than three percent of the total services rendered but consumed 43 percent of the total funding.

Admittedly, these studies are too narrow to support definitive conclusions. They do, however, indicate that the need is great, the fees being charged are moderate and that care for children is substantially less expensive than for adults, particularly elderly adults whose oral health has been badly undermined by years of neglect.

The lack of emphasis on children's preventive services is one aspect of medicaid's operation that has contributed to the present unsatisfactory situation. Two other matters during the life of the program have received sufficient public attention that we should like to comment briefly on them. One is the question of fees and the other is quality control.

There has been a tendency upon the part of some to blame the escalation of medicaid spending upon spiraling practitioner's fees. In the case of dentistry, this is simply not so. In New York, as a first example, medicaid dental fees were originally set in 1966 and, since that time, there has been only one major change, a 20-percent reduction of them. In California, which is the second largest participant in medicaid dental services, the fee was first set at the 19th percentile of usual and customary fees and remained there until a few months ago, when it was raised to the 40th percentile.

Some of the largest payments under the California program have been made to advertising dentists whose practices concentrate on mass production of dentures. In 1968, one of these men received some $650,000, seven others received more than $100,000 each. These practitioners are not eligible for membership in the American Dental Association because advertising to the public violates the association's principles of ethics.

Similar schedules are in existence in all the other States. In no State are medicaid dental fee payments at the Federal ceiling of the 75th percentile.

It would, of course, be possible for percentile fee arrangements to escalate unnecessarily if usual and customary fees had done so. Again, this has not been the case with respect to dental fees. An appended table—appendix II—shows the percentage increase in dental fees both over a long-term period and in the past 3 years. These percentages are derived from figures supplied by the Consumer Price Index compiled by the Bureau of Labor Statistics. Both columns of the table indicate that dental fees have risen less sharply not only than other elements within the "medical care" index item but also less than the item for all services, less rent, that are measured by the CPI.

Such statistics as these, of course, reflect general trends within the nationwide profession. They do not eliminate the possibility that an individual practitioner has taken advantage of his patients in terms of fees charged or, in the case of the needy or medically needy, taken advantage of the Government. You have had before you an administrator of the New York City medicaid program who says he found, within his jurisdiction, evidence of some such abuse. We have not had an opportunity to analyze his findings but if, as he asserts, some individual dentists have abused the medicaid program, they should be

brought as severely and swiftly to account as anyone else who perpetrates a fraud. Ample machinery exists to do so and we fully support it being brought into play.

In California, we have found that dentistry is the least abused and most easily controlled of any of the offered services.

In the matter of both fees and quality control we should like to call the committee's attention to the existence in many States of dental service corporations. These private, nonprofit organizations are authorized by the States within which they operate to offer dental insurance coverage on a group basis. The dental service corporation in California, which is the largest in the Nation, now provides coverage for some 2 million people. These corporations have boards with representation from both the profession and the public. There is careful, prior discussion of the services to be offered and the fees to be paid. There is full understanding, at the beginning, of what is mutually equitable to those covered, frequently members of unions, and those providing the service.

The experience has been exceptionally good in terms of anticipating potential abuse, monitoring the operation of the program, and moving quickly to resolve any case where a question arises. Everyone involved understands that lingering suspicion about abuse can only inhibit the soundness of the program, harm the reputation of the participating practitioners, and destroy the faith in the program that those covered must have.

Those responsible for medicaid might find it worthwhile to study the administrative structure of such groups as the California Dental Service or Michigan Dental Care, Inc., as to how they achieve their ends and maintain cordial full faith with the beneficiaries. The staff of the national association of these corporations, Delta Dental Plans, would also be more than happy to help. Quality control through peer review is also an established feature of these corporations. Perhaps one reason for their success is that there is full and mutually candid consultation at the beginning and regularly thereafter. One governmental habit that has been fatal to the fostering of such a relationship is that which brings the local dental society into consultation only after most of the preliminary decisions have been made.

In effect, the society is told, "There are x number of people in this program eligible for dental care and we have decided we can afford to allot x dollars to it. Here is a list of the services we would like to include." This has happened more than once and, though the motivation is doubtlessly always innocent, it is invariably the breeding ground for unnecessary ill feeling on both sides.

The American Dental Association, at the request of the Medical Services Administration, has prepared guidelines for dental care under title XIX. They are appended to this statement. The guidelines call specifically for peer review mechanisms. We think the guidelines are realistic, equitable, and professionally sound. We would be glad to discuss changes in them if that seems desirable. We would certainly like them to be used more often and more fully than they are, particularly those sections that pertain to priorities in care when the dollar amounts available are limited.

Mr. Chairman, this concludes our statement. We are pleased to have this opportunity to appear before the special subcommittee. Mr. Con-

way. Mr. Christensen and I would be glad now to respond to any questions.

Senator Anderson. Senator Ribicoff?

Senator Ribicoff. I have one question, Dr. Dewhirst.

Dr. Bellin appeared last week before us. He is head of the New York City Health Department. He told us that a recent audit of dental work performed on 1,300 medicaid patients of dentists with high-volume medicaid practices showed that in 9 percent of the cases no evidence that the work billed for had been performed: in another 9 percent, the quality of the work was grossly substandard. The study also showed that 60 percent of a series of about 900 dentures represented unsatisfactory craftsmanship.

What does organized dentistry do to follow up on this type of conduct in action?

Dr. Dewhirst. We have established within the California setup, which is the one that I am best acquainted with, a preauthorization. The work has to be authorized in advance so that you have an opportunity to inspect the X-rays and judge the work that is contemplated. Then they have postcheck reviews to see that the work is performed as outlined. Then with selected cases—I do not know whether it is every fifth or every third case—they check upon the quality of the work that is also done.

The figures that were mentioned by the gentleman from New York were admittedly problem cases that were selected.

Senator Ribicoff. No, they were not. They were taken at random.

Dr. Dewhirst. He says in his statement that these were cases where either fraud was suspected or where the patients had complained about the work or where there was some other difficulty. So this is a very small, select group that he has taken from a very large number of cases that are treated.

Senator Ribicoff. Well, as I understand, and I am trying to recall what he said, they took the cases where there were large bills under medicaid from dentists and where people came in and had a complaint. So there was a substantial number of cases. And of course, when they went into this, also a dentist examined them—these were not laymen who were making these examinations who came up with these figures.

Dr. Dewhirst. I understand.

Senator Ribicoff. One of the problems is what do you do in California in a situation where there is constantly repeated and it comes to your attention that dentist X is really not a competent dentist. What do you do about lifting his license?

Dr. Dewhirst. This is a difficult area and one in which few licenses have ever been lifted, I will admit. The dental association, which does not have licensing authority, does remove from society membership those who are consistently doing substandard dentistry or are uncooperative. And we, in our counseling or our grievance committees, where you continually have cases brought before you of one particular dentist who is having problems with his patients, we either insist that he goes back to school and take postgraduate work or that he no longer performs this particular dental service.

Senator Ribicoff. You take in your State of California. I think it applies to dentistry. Insurance premiums in malpractice cases are

rising to fantastic sums. Doctors are paying very, very large fees for malpractice insurance. Does that prevail, too, in dentistry?

Dr. DEWHIRST. Dentistry has not had the same experience.

Senator RIBICOFF. But you are starting to worry about it?

Dr. DEWHIRST. Yes, we are concerned about this type of thing. When third-party type of programs came into effect, premedicare, the mechanisms were instituted which allows much better control than existed previously.

Senator RIBICOFF. What is the responsibility of a dental association or a medical association against a person who is continuously involved in malpractice?

Dr. DEWHIRST. Well, the responsibility is part of a peer review mechanism. We bring them up for trial and then, at the end of the chain of command as far as the dental association is concerned, this may be turned over to the State board of dental examiners in our State.

Senator RIBICOFF. But nothing much ever happens?

Dr. DEWHIRST. There have been a few licenses lifted. But until third party situations began, where there are better mechanisms for receiving complaints, few cases, except in the case of gross malpractice or where somebody commits a fraud or something, led to the loss of license.

Senator RIBICOFF. That is all.

Senator ANDERSON. Senator Williams?

Senator WILLIAMS. No questions.

Senator ANDERSON. Thank you very much for coming in and testifying. We appreciate it.

(Attachments to Mr. Dewhirst's statement follow:)

APPENDIX I

AMERICAN DENTAL ASSOCIATION GUIDELINES FOR DENTAL PROGRAMS UNDER TITLE XIX

THE NATURE OF THE DENTAL PROBLEM

Prevelance of Dental Disease.—Dental disease is the most common health problem. Dental decay is early universal, beginning at a very early age and continuing throughout life. By age two, 50 percent of children have decayed teeth. Surveys show an average incidence of one new cavity per year in children aged 6 to 11 years, and one and one-half cavities a year in children aged 12 to 15 years.

Periodontal disease, the next most common dental problem, affects three fourths of adults by age 50. This disease begins early in life and, if uncontrolled, will eventually result in loss of teeth.

The accumulated effects of dental disease are demonstrated by the fact that 1 percent of persons between ages 18 and 24 have lost all their teeth while almost 50 percent of persons aged 65 to 74 have lost all their teeth. It is well known by the dental profession that many people who require dentures could have saved their natural teeth with regular care and preventive measures initiated at an early age.

Utilization of Dentists' Services.—Dental problems are created and compounded by the low level of utilization of dentists' services. About one half of all children in the United States under age 15 have never been to a dentist. For children in rural areas, the percentage is even higher.

The seeking of dentists' services is related to the educational and income level of the family, the availability of dental service, and the effectiveness and organization of dental programs. The relationship of family income to dental care is indicated by the finding that 66 percent of children in families with incomes under $4,000 have never been to a dentist, compared to 40 percent of children from families with incomes of $4,000 or more.

Utilization of dentists' services can be increased by removing or reducing financial barriers as demonstrated by the experience of dental prepayment programs. Utilization was increased to 70 percent in a program for children which included a periodic recall system. An effective program of dental health education can also increase utilization.

The Importance of Prevention.—The dental profession has long urged the use of proven preventive procedures which can significantly reduce the incidence of dental disease and the total dimensions of the dental problem. The following preventive measures should be fully employed:

Full use of Fluorides.—Fluoridation of the communal water supply can reduce the incidence of dental decay approximately 60 percent. Every state and community should provide the benefits of water fluoridation to its citizens to the maximum degree possible. It has been demonstrated that the cost of dental care programs for children in nonfluoridated communities is more than double the cost for children in fluoridated communities. In areas without a community water supply, consideration should be given to fluoridation of school water supplies.

Where fluoridation of the public water supply is not feasible, provision should be made for the topical application of fluorides or for the use, when indicated, of dietary fluoride supplements.

Anticariogenic Dentifrices.—The use of effective anticariogenic dentifrices should be encouraged.

Control of Consumption of Sweets.—Educational campaigns should be conducted to reduce the frequency of consumption of sweets. Special attention should be given to the elimination of the sale of sweets in schools.

Toothbrushing Instruction.—Toothbrushing instruction and regular oral prophylaxis should be encouraged, starting at an early age.

Malocclusion.—To prevent malocclusion, decayed teeth should be restored, spaces resulting from the early loss of primary teeth should be maintained where indicated, and deleterious oral habits should be corrected. Determinations of need for orthodontic treatment can be assisted by the available index for the assessment of handicapping malocclusion.

Dental Health Education.—Comprehensive and continuing dental health education for the individual patient and the public should be an essential component of all treatment programs.

THE DESIGN OF THE DENTAL PROGRAM

Advisory Committee.—In accordance with the "Handbook of Public Assistance Administration." D-7220 and D-7520, state plans are required to have at least the part-time services of a dentist included in the medical assistance unit in the state agency office.

It is recommended, in view of Sec. 1902(a)-30, that the state administrative agency establish an additional dental advisory committee in conjunction with the state dental association. This committee should consist of at least five dentists. It could be financially supported under Sec. 1903(a). The guidance of a dental advisory committee would be most valuable in designing and administering the dental program.

Priority of Care to be Provided.—The goal of dental care programs should be to provide comprehensive dental care for all eligible segments of the population. When necessary because of financial or other limitations, a system for priority of care should be established. Experience has demonstrated that a comprehensive program for one segment of the eligible population can be a better approach to the goal than a fragmented care program for all.

Relief of pain and infection and necessary diagnostic procedures should be provided to all eligible recipients. The highest priority for comprehensive care should be given to a program for children. Other segments of the population should be added as the program expands so that all eligible recipients will have dental care during or before 1974 as required in the law.

It is recommended that a care program for children be initiated for a specified age group and be expanded on a systematic basis to include initial care for additional age groups and maintenance care for all children in the program.

Services for Children.—The program should provide all indicated treatment necessary to restore and maintain the dental and total health of the child. All programs should be designed to include:

Complete examination and diagnosis including radiographs when indicated.
Elimination of pain and infection.
Treatment of injuries.
Elimination of diseases of bone and soft tissue.
Treatment of anomalies.
Restoration of decayed or fractured teeth.
Maintenance or recovery of space between teeth when this service will affect occlusion.
Replacement of missing permanent teeth.
Treatment of malocclusion with priority for interceptive treatment and disfiguring and handicapping malocclusion.
Periodic recall for preventive and treatment services.

Services for Adults.—A state may choose to implement a dental program for a segment of the population in addition to children. A program for adults should provide all indicated treatment services necessary to restore and maintain the dental and total health of the patient. Programs should be designed to include the following services in accordance with the need of the specific program:

Complete examination and diagnosis including radiographs as indicated.
Elimination of pain and infection.
Treatment of injuries.
Elimination of diseases of bone and soft tissue.
Treatment of anomalies.
Restoration of decayed or fractured teeth.
Maintenance or recovery of space between teeth when this service will affect occlusion.
Replacement of missing teeth.
Early detection of oral manifestations of systematic diseases and treatment of oral lesions.

If financial limitations will not allow a comprehensive program for adults, the following sequence of treatment is recommended:

Treatment of acute conditions and elimination of pain and infection.
Complete examination and radiographs when indicated.
Treatment of diseases of bone and soft tissue with restoration of decayed teeth.
Replacement of missing teeth with full or partial prosthesis.

Treatment for Special Population Groups.—It is recommended that specific arrangements be made for the provision of dental care for handicapped persons who are homebound or residing in institutions or nursing homes. These special population groups have often been neglected in organizing dental programs of state and local governments. Services provided should include examinations at regular, periodic intervals and preventive maintenance care. The dental profession should be involved in the planning, operation and evaluation of programs for these special groups.

Fiscal Administration.—The state administrative agency should establish the usual, customary, and prevailing fee mechanism to assure quality care and broad participation by the profession. The use of a fiscal intermediary, such as a state dental service corporation or other qualified agency, is encouraged.

Methods of Providing Services—The program should utilize to the fullest extent existing dental facilities and resources, especially those of private practice. The provision of dental treatment through private practice should be the preferred method in order to restore the eligible recipients to the mainstream of society. Freedom of choice should be preserved for both patient and practitioner. Increased manpower recruitment should be encoruaged in areas where there is a shortage of health manpower.

Program Evaluation.—Provision should be made for periodic evaluation of quantity and types of dental care provided to provide information for improving or extending the dental program. The administering agency should use uniform methods for accounting, tabulations, and identification of services to provide data on costs, utilization, and services rendered.

Evaluation should be extended to the systems of delivery of care to assure that all eligible recipients have access to quality care.

Review of Care Provided.—Programs should utilize mechanisms developed by the dental advisory group for peer review—the professional review of treatment provided. Review committees should be established at the local level in cooperation with local dental societies. The mechanisms for quality evaluation should be reviewed to assure objectivity and effectiveness.

CONCLUSION

In planning dental care programs under Title XIX, it is recommended that care be provided according to the following priorities:

Emergency care for all recipients.
Establishment of care programs for children.
Comprehensive care for additional age groups as funds become available.
Comprehensive care for adults.

The requirements of the program should not in any way impair the professional judgment of the dental profession in providing treatment, or cause the treatment provided under the program to be inferior to that provided in the private sector of dental practice.

APPENDIX II

PERCENTAGE INCREASE IN DENTAL FEES MEASURED AGAINST OTHER CPI ITEMS

	1935-69	1966 to February 1970
Dental fees	177	21.9
Physicians' services	188	25.8
Hospital daily service charges	976	64.0
All "medical care"	214	25.4
All measured services, less rent	(1)	22.3
CPI	167	17.2

[1] Not available.

STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. NOLAND. Mr. Chairman, my name is Royce Noland. I am the executive director of the American Physical Therapy Association. In the past 2 years, I have been privileged to review reports of field visits and reviews of utilization patterns in various provider facilities under the medicare program. It is disturbing to note that in certain instances the service of physical therapy, or that service which was claimed to be physical therapy, has not been consistent with quality care or represent utilization patterns which exceed normal reasonable community standards. I have carefully reviewed items noted in the report of the staff of the Committee on Finance which identifies the more profound and bizarre situations in which there was obvious inappropriate use of physical therapy.

Through other channels I have been made cognizant of similar situations. It is disconcerting to me as a representative of a profession to note that there has been ill use or excessive claims in the name of physical therapy. I am not embarrassed by the existence of this situation. Having recognized the existence, however, of any abuse, the next appropriate step, instead of "handwringing" over its existence, is to make constructive recommendations that will bring about a more effective utilization of physical therapy under the program.

I must note that the program itself has been a component of the problem. Fundamental to this problem was the singular recognition of the provider as the responsible party and the rationale that there was a need for the provider category to render "supervision and direction" of the care. I would state categorically that neither the nursing home industry nor those agencies that are certified as home health agencies have the expertise or personnel to perform this function. Since it is in these two provider categories that most of the identified abuses occurred, it seems in order to concentrate in that direction.

I would suggest, then, without dismantling the system of provider categories that emphasis be made in the law and regulations which would place a greater responsibility on the shoulder of the respective health professionals actually rendering the care regardless of the setting. This need not produce new administrative burdens for those in Government or the intermediaries.

The medicare program may be described in many ways, but it is our observation that regardless of other names which might be applied to it, it is a "third party payer program." If the goal of optimum care for the least expenditure is to be achieved, we all should take lessons from other third party payer programs, for there are valuable lessons to be learned. The most important ingredient in any third party payer program is a neutral arbitrator of the appropriateness of care and charges. This has been referred to as utilization review, peer review, and professional audit. In the presence of any third party payer program, peer review is more than just desirable, it is mandatory.

The time has passed when the provider of health care and the patient could get together, determine the quantity of care, the nature of the care, and the cost of care, and then dictate all of those determinations to the third party payer. On the other hand, no one would accept these determinations being made solely by the third party payer. The logical solution then is a neutral, voluntary peer review group.

However, peer review will be effective and valuable only when it is just that; a review of services by persons especially knowledgeable of that service. Physicians' services must be reviewed by physicians and physical therapists must be involved in the review of physical therapy services. This is fundamental. There are two other aspects of peer review which are vital if it is to effectively fulfill its mission. They are:

1. The review body be disinvolved with the agency providing the service or the person within the agency providing the service. The concept of internal utilization review is impractical and will be ineffective as long as human beings are doing it. Internal utilization review, as I have seen it function, is more like a "mutual admiration society meeting" than an effective, objective, and valuable review of services being provided. Therefore, the review body should be separate and distinct and in no way identified with the institution or persons providing the care.

2. Medicare program peer review should not be an option. It should be a mandatory component of the process for payment of claims. It should be made mandatory as part of the services of the fiscal intermediary. This demand for peer review should not only originate with Government but should be open to the professions involved in delivery of service and the public to also demand it when circumstances warrant it.

The other aspect of this which deserves attention is the concern over cost, concern which we share with those of you in Government. It has been most disturbing to us to see a skyrocketing of costs for physical therapy services under this program. What is remarkable is that the concept of reimbursable cost was supposed to have had an impact of holding costs down, but actual experience has demonstrated that the reimbursable cost method of claims payment has produced costs profoundly higher than using the prevailing fee schedules in the community.

This was true at the beginning of the program and there continues to be a wide gap between the cost of physical therapy services under medicare versus amounts being paid for the same service by other third party payers. Contrary to the response of other health professions, we would advocate the establishment of negotiated but arbitrary fee schedules for the service of physical therapy which should constitute a ceiling.

I am suggesting, then, that the "ground rules" be such that the provider may be paid his appropriate reimbursable cost or the negotiated fee schedule, whichever is less. When I refer to a negotiated fee schedule, I mean a schedule negotiated within each state involving the intermediaries, the State agency and the respective profession involved.

In the field of physical therapy there is considerable precedent for this kind of negotiated fee schedule with third party payers. It is more sophisticated in some States than others but we are prepared to furnish to this committee, or anyone involved in the administration of the program, general guidelines for reasonable fee schedules.

This would not represent the concept of "usual and prevailing charges," but would be a carefully determined fee schedule. We would advocate the relative values method which takes into account skill, equipment used, and time. This method of determining a fee schedule has many years of experience for background. We can see no reason why the medicare cost for physical therapy should be any higher than those for any other third party payer, but until such time as the State agencies, the intermediaries, Social Security Administration, and other involved parties are willing to collaborate with us, we do not see an early resolve of the cost problems surrounding this program.

I imply then that there has been reluctance on the part of the various agencies to even discuss these concepts with us. I state categorically that our Association and each of our State chapters has made unusual efforts to discuss problems related to physical therapy in the medicare program with intermediaries, with State agencies, with regional offices of SSA, and Public Health Services. These efforts have generally been to no avail until this committee, via the staff report, caused them to pay attention to physical therapy. The reaction was overreaction.

I would note to this committee that the American Physical Therapy Association and its component State chapters are prepared and have been prepared and has eagerly awaited the opportunity to help develop and participate in a series of control mechanisms. These include: (1) program for utilization review (2) program for determining guidelines for scope of care (3) program for determining appropriateness of charges, and (4) program for consultation.

Perhaps the stimulus of action by this committee can cause the administrators of the program to exploit this reservoir of assistance which we have stood ready to provide and continue to stand ready to provide.

Thank you.

Senator Anderson. I would like to commend you for your fine testimony.

Senator Williams?

Senator Williams. I have no questions.

The staff has some questions it would like to ask.

The STAFF. A few questions for the record. Are you aware of instances where physical therapists visit nursing homes and lead five or 10 patients in a series of exercises simultaneously and submit multiple bills for therapy services?

Mr. NOLAND. I recall in the staff report there was an illustration of the situation. I believe it was noted as physical therapist aid. I do not remember whether there was a physical therapist present or even on the payroll of the extended care facility.

The concept of group exercise per se is not out of order. It is an appropriate way to carry on an exercise program for a number of elderly patients. The charge method, however, is disturbing to us.

STAFF. Earlier. Dr. Apple referred to kickbacks between nursing homes and pharmacies and the solicitation of kickbacks by nursing homes and some pharmacists. Are you familiar with or are you aware of any similar kickback arrangements between physical therapists and nursing homes?

Mr. NOLAND. Since essentially the same problems exist as far as pharmacists are concerned with the physical therapists I would have to presume that this would be the case. I cannot identify any percentage or how prevalent it is. But as long as the only claimant can be the provider of service, it does put anyone rendering service in the nursing home in a position of collaborating or not being there at all.

STAFF. Do any of your State or local units have any organized peer review activities at the present time?

Mr. NOLAND. Yes, sir.

STAFF. Is it a matter of policy for the Physical Therapy Association component units to have such review activities?

Mr. NOLAND. It is a matter of policy for the State units to have such bodies. A number of States do.

I would note that in one particular State, these have been in existence for several years. They were widely advertised to the intermediaries and other regulatory bodies, and a 2-year period passed before they were used for the first time.

STAFF. Have any cases of fraud by therapists been referred to your organization for review, and if so, what action did you take?

Mr. NOLAND. There is not a mechanism to handle this nationally. It would only be in a component unit. But yes, they have. The response was to refer it to the peer review body and submit this report to the intermediary, who has the ultimate authority to accept or reject a claim.

STAFF. We have had reports of cases in which patients were billed for numerous modalities of treatment during one visit. For example, the therapist might place heating pads on both legs and exercise one arm and then charge for three separate services. Could you explain this modality billing process, and is this a just way of charging?

Mr. NOLAND. The other mechanism that is used is to use three different modalities to the same part and make a separate charge for each of them.

STAFF. How do you do that?

Mr. NOLAND. For example, ou could use infrared, diathermy and hot packs on the one spot—not simultaneously—that would be three different modalities. I have been informed that some extended care facilities

actually charge for three different items. Of course, in either illustration, that is a ridiculous method of charging.

Under the relative value method, where you combine method and time, this would not occur. For example, if the charge in this instance were $8 per modality, if the relative value schedule were used, the total charge would probably amount to say, using a $6 conversion unit, about $8.50 for all three versus the $24 which I understand some extended care facilities have charged the intermediary.

STAFF. Thank you.

Senator ANDERSON. Thank you, Mr. Noland.

Senator Williams?

Senator WILLIAMS. I have no questions.

(Mr. Noland's prepared statement follows:)

PREPARED STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Since the time of Hippocrates those in the health professions and those concerned with society as a whole, including government, have attempted to separate the word "treat" from the word "treatment." It is my observation that we have all failed miserably. Perhaps the reason is because it is an impossible separation. I would suggest that this is a major portion of the problem which we face when we are reviewing what appears to be over-utilization of the Medicare program or any health care program.

In the past two years I have been privileged to review reports of field visits and reviews of utilization patterns in various provider facilities under the Medicare program. It is disturbing to note that in certain instances the service of physical therapy, or that service which was claimed to be physical therapy, has not been consistent with quality care or represent utilization patterns which exceed normal reasonable community standards. I have carefully reviewed items noted in the report of the staff of the Committee on Finance which identifies the more profound and bizarre situations in which there was obvious inappropriate use of physical therapy.

Through other channels I have been made cognizant of similar situations. It is disconcerting to me as a representative of a profession to note that there has been ill use or excessive claims in the name of physical therapy. I am not embarrassed by the existence of the situation. Adam did indeed take a bite of the apple and we have all recognized the inperfection of Man since that time. Therefore, the existence of a few people who would choose to abuse a program should come as no surprise to the Committee and it certainly comes as no surprise to me. I would insist that my careful observations of this situation, since the inception of the program, make it clear that the presence of this abuse does not represent the normal behavior of the average physical therapist, but instead is a profile of isolated activity limited to a very few. Having recognized the existence, however of any abuse, the next appropriate step, instead of "hand-wringing" over its existence, is to make constructive recommendations that will bring about a more effective utilization of physical therapy under the program.

I must note that the program itself has been a component of the problem. Fundamental to this problem was the singular recognition of the provider as the responsible party and the rationale that there was a need for the provider category to render "supervision and direction" of the care. I would state categorically that neither the nursing home industry nor those agencies that are certified as home health agencies have the expertise or personnel to perform this function. Since it is in these two provider categories that most of the identified abuses occurred, it seems in order to concentrate in that direction.

The standards and regulations for an extended care facility not withstanding, physical therapy service in this setting represents little more than a glorified home call for the physical therapist. The administrative and medical management inadequacies of these facilities have contributed to the presence of those abuses which have been identified. This is not an attempt to shift responsibility nor is it intended to criticise a given industry, but I am suggesting that the responsibilities delegated to the extended care facilities and the home health agen-

cies for administrative or medical management were unrealistic and inconsistent with their capabilities at the inception of the program and remain so today.

I would suggest, then, without dismantling the system of provider categories that emphasis be made in the law and regulations which would place a greater responsibility on the shoulder of the respective health professionals actually rendering the care regardless of the setting. This need not produce new administrative burdens for those in government or the intermediaries.

Unlike many who have come before this Committee recommending greater expenditures for the program, I suggest that optimum care for the beneficiary group could and should be gained with a lesser expenditure. I would also state that this is particularly true in the area of physical therapy services.

The Medicare program may be described in many ways, but it is our observation that regardless of other names which might be applied to it, it is a "third party payer program." If the goal of optimum care for the least expenditure is to be achieved we all should take lessons from other third party payer programs, for there are valuable lessons to be learned. The most important ingredient in any third party payer program is a neutral arbitrator of the appropriateness of care and charges. This has been referred to as utilization review, peer review, and professional audit. In the presence of any third party payer program, peer review is more than just desirable, it is mandatory.

The time has passed when the provider of health care and the patient could get together, determine the quality of care, the nature of the care, and the cost of care and then dictate all of those determinations to the third party payer. On other hand, no one would accept these determinations being made solely by the third party payer. The logical solution then is a neutral, voluntary peer review group.

However, peer review will be effective and valuable only when it is just that: a review of services by persons especially knowledgeable of that service. Physicians' services must be reviewed by physicians and physical therapists must be involved in the review of physical therapy services. This is fundamental. There are two other aspect of peer review which are vital if it is to effectively fulfill its mission. They are:

1. The review body be disinvolved with the agency providing the service or the person within the agency providing the service. The concept of internal utilization review is impractical and will be ineffective as long as human beings are doing it. Internal utilization review, as I have seen it function, is more like a "mutual admiration society meeting" than an effective, objective and valuable review of services being provided. Therefore, the review body should be separate and distinct and in no way identified with the institution or persons providing the care.

2. Medicare program peer review should not be an option. It should be a mandatory component of the process for payment of claims. It should be made mandatory as part of the services of the fiscal intermediary. This demand for peer review should not only originate with government but shoud be open to the professions involved in delivery of service the public to also demand it when circumstances warrant it.

As I note in my earlier testimony, I have been made cognizant of several field audits of various providers in which there was apparent abuse of the program in reference to claims for physical therapy and other services. Inherent in all of these reports were statements on the weakness of the review process. I would respond then to those who suggest that the peer review system is not working. How could they know? It has never been tried—tried in the sense of being independent and mandatory.

The other aspect of this which deserves attention is the concern over cost. A concern which we share with those of you in government. It has been most disturbing to us to see a skyrocketing of costs for physical therapy services under this program. What is remarkable is that the concept of reimbursable cost was supposed to have had an impact of holding costs down, but actual experience has demonstrated that the reimbursable cost method of claims payment has produced costs profoundly higher than using the prevailing fee schedules in the community.

This was true at the beginning of the program and there continues to be a wide gap between the cost of physical thereapy services under Medicare versus amounts being paid for the same service by other third party payers. Contrary to the response of other health professions, we would advocate the establishment of negotiated, but arbitrary fee schedules for the service of physical therapy which should consitute a ceiling.

I am suggesting, then, that the "ground rules" be such that the provider may be paid his appropriate reimbursable cost or the negotiated fee schedule, whichever is less. When I refer to a negotiated fee schedule, I mean a schedule negotiated within each state involving the intermediaries, the state agency and the respective profession involved.

In the field of physical therapy there is considerable precedent for this kind of negotiated fee schedule with third party payers. It is more sophisticated in some than others but we are prepared to furnish to this Committee, or anyone involved in the administration of the program, general guidelines for reasonable fee schedules.

This would not represent the concept of "usual and prevailing charges," but would be a carefully determined fee schedule. We would advocate the relative values method which takes into account skill, equipment used, and time. This method of determining a fee schedule has many years of experience for background. We can see no reason why the Medicare cost for physical therapy should be any higher than those for any other third party payer, but until such time as the state agencies, the intermediaries, Social Security Administration, and other involved parties are willing to collaborate with us, we do not see an early resolve of the cost problems surrounding this program.

I imply then that there has been reluctance on the part of the various agencies to even discuss these concepts with us. I state categorically that our Association and each of our state chapters has made unusual efforts to discuss problems related to physical therapy in the Medicare program with intermediaries, with state agencies, with regional offices of SSA, and Public Health Services. These efforts have generally been to no avail until this Committee, via the staff report, caused them to pay attention to physical therapy. Then the reaction was overreaction.

I would note to this Committee that the American Physical Therapy Association and its component state chapters are prepared and have been prepared and has eagerly awaited the opportunity to help develop and participate in a series of control mechanisms. These include: (1) program for utilization review (2) program for determining guidelines for scope of care (3) program for determining appropriateness of charges, and (4) program for consultation.

We still stand prepared to offer these services to any of the involved responsible agencies involved in the Medicare program and only seek the opportunity to present these concepts and work with the responsible parties administering the Medicare program. As these are revealed it is obvious that they do not represent any kind of self-seeking or vested interest. They are programs intended to bring about reasonable control and optimum utilization, at costs which represent value received.

Perhaps the stimulus of action by this Committee can cause the administrators of the program to exploit this reservoir of assistance which we have stood ready to provide and continue to stand ready to provide.

Senator Anderson. The hearing will be recessed subject to the call of the Chair.

Thank you very much.

(Whereupon, at 12:05 p.m., the hearing recessed subject to the call of the Chair.)

(By direction of the chairman, the following communication, with attachment, is made a part of the printed record:)

Greater New York's Blue Shield,
United Medical Service, Inc.,
New York, N.Y., July 28, 1970.

Mr. Jay B. Constantine,
Professional Staff Member, United States Senate,
Committee on Finance, Washington, D.C.

Dear Mr. Constantine: Thank you for your letter asking me to comment on the accuracy of Mr. Sale's memorandum to Dean Lewis Thomas, M.D., of the New York University Medical Center, especially in reference to the last line in the third paragraph of the memorandum.

Mr. Sale's statement that UMS would honor requests for reimbursement for every in-hospital day visit "regardless of evidence (or the lack thereof) in the patients' charts" is completely inaccurate. In our meetings with representatives of the New York University Medical Center, including Mr. Sale, certain ground

rules under which reimbursement would be provided for every in-hospital day visit were emphasized and were subsequently put in writing.

Enclosed is a memorandum which identifies both regulations and guidelines. I call your attention to the last paragraph on page 2 and to items (3) and (4) on page 3 with respect to this matter. This memorandum was made available to the Greater New York Hospital Association on December 6, 1967 and was also distributed to hospital administrators and presidents of the medical boards of all hospitals billing for the services of attending physicians to Medicare beneficiaries in the teaching setting.

Further enclosed is a copy of my talk on "Reimbursement of Physicians in the Teaching Setting," which was given in the auditorium of the New York University Medical Center on September 27, 1967. Mr. Sale attended this metting at his institution. Pages 3 and 4 of this presentation by me again emphasized, not only the regulations, but also the ground rules that we established for billings made in the teaching setting.

I hope this information will be helpful to you.

Sincerely,

HAROLD J. SAFIAN, M.D.,
Senior Vice President.

Enclosures (2).

MEMORANDUM

The Social Security Administration feels that a memorandum relating to reimbursement for the services of attending physicians in the teaching setting to Medicare beneficiaries might be helpful in clarifying any possible misunderstandings that might arise in billing for these services.

Intermediary Letters No. 196 and 221 issued by the Bureau of Health Insurance, Social Security Administration, transmitted regulations governing conditions under which Part B payments may be made for the services that physicians, other than interns and residents, perform in the teaching setting.

Where a physician performs services in the teaching setting as a Medicare patient's attending physician, Part B payments may be billed for—

(1) by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients),

(2) by the hospital, or

(3) if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his behalf. The organization must furnish to the Part B Carrier, United Medical Service, the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed of changes on a current basis.

Where the hospital bills for the services of attending physicians to Medicare beneficiaries in the teaching setting, *it must use the SSA–1554.*

If an individual physician bills on an SSA–1490, *he must identify the name of the hospital* in which the services were rendered, and *he must identify that he is billing for services in the teaching setting.* In fact, all bills from any entity for services rendered in the teaching setting must be identified as such to the Part B Carrier.

In general, in the area administered by United Medical Service as the Part B Carrier, teaching physicians of a hospital, billing through a hospital or other organization, adopted a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting. Intermediary Letter No. 221 indicates that if as a result of using such a uniform schedule of charges, or for any other reason, an attending physician charges different amounts for his services to teaching patients and for his services to other patients, such charges should not be taken into account in determining his reasonable charge for patients outside the teaching setting.

Approval of these schedules by the Part B Carrier as being reasonable charges in accordance with the principles of reimbursement included, as a result of discussions with teaching physicians and their representatives, acceptable guidelines for billing and auditing purposes. *These guidelines* for in-patient services *are identified for information as follows:*

(1) *There must be a personal and identifiable service* by the attending physician to the Medicare beneficiary demonstrated by such actions as—

reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission

confirming or revising diagnosis

determining the course of treatment to be followed

assuring that any supervision needed by the interns and residents was furnished

and by making frequent reviews of the patient's progress.

(2) Personal and identifiable services by the attending physician to the Medicare beneficiary should be identified in the patient's hospital chart by recording an admission note, progress notes at least every third day, and a discharge note.

(3) In the case of major surgical procedures and other complex and dangerous procedures or situations, *personal and identifiable service must include supervision in person by the attending physician.*

Where surgical procedures are being performed by interns and residents, other than fourth or fifth year residents, supervision in person by the attending physician should include his presence as part of the operating team.

Where surgical procedures are performed by fourth and fifth year residents, and the teaching program requires the presence of the attending physician, supervision in person requires physical presence in the operating room of the attending physician during surgery. The attending physician's name should appear on the operative record.

Where surgical procedures are performed by fourth and fifth year residents, and the teaching program does not require the presence of the attending physician, there should not be a bill submitted for his services. However, billing is acceptable for personal and identifiable services rendered to Medicare beneficiaries by the attending physician during the pre- and post-operative period of hospitalization.

(4) *If there are no personal and identifiable services rendered to a Medicare beneficiary by the attending physician* in the teaching setting and a patient's care in the teaching program is primarily the responsibility of the resident, *billing should not be made in the name of the attending physician for Part B reimbursement.*

(5) Reimbursement for the services of attending physicians in the teaching setting to Medicare beneficiaries in the out-patient clinics also requires a personal and identifiable service. For billing purposes, medical care rendered to the patient by the attending physician should be identified in writing on the out-patient clinic chart.

Reimbursement of Physicians in the Teaching Setting

PRESENTED AT THE GREATER NEW YORK HOSPITAL ASSOCIATION MEETING, SEPTEMBER 27, 1967

(By Harold J. Safian, M.D., Vice President—Medical Affairs, United Medical Service Inc.)

Reimbursement for the services of attending physicians in a teaching setting has long been an issue in New York. Shortly after the implementation of the Medicare Program in July, 1966, United Medical Service and other Carriers received inquiries as to whether reimbursement would be provided from Part B funds for services rendered in the teaching setting in addition to recognition given under Part A to intern and resident services in approved hospital teaching programs.

The Social Security Administration was faced with the problem of whether under Title XVIII of the Act, the issue of reimbursement for the services of attending physicians teaching interns and residents was also a covered expense under Part B of Medicare. The decision by the SSA was not readily forthcoming and UMS advised hospitals and attending staffs in our area not to submit claims on service cases and out-patient clinic patients forming the bulk of the teaching program until more specific direction had been given to the Carriers by the SSA. UMS and other Carriers pursued this problem with SSA representatives in Baltimore but it was not until February, 1967 that SSA issued proposed guide-

lines governing reimbursement for the services of attending physicians to Medicare beneficiaries in a teaching setting. These proposed Regulations were issued on February 3, 1967 in Intermediary Letter #196 and further clarified in Intermediary Letter #221 dated April 21, 1967.

As some of you know, because of the time lag involved in the issuance of the Regulations and in the discussions that followed to arrive at an equitable reimbursement for services in a teaching setting, a certain urgency developed in our desire to deal with the backlog of these cases that have accumulated since July, 1966. After considerable discussion with hospital administrators and physicians reperesenting their attending staffs, together with Regional Representatives of the Social Security Administration who participated in these meetings, it was felt the most reasonable approach at this time would be to adopt a mutually acceptable uniform schedule of reimbursement for these services in the teaching hospitals.

Regulations provide that teaching physicians of the hospital might wish to adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting. Regulations further state that the uniform schedule of charges would be acceptable so long as the scheduled charges were not in excess of prevailing fees in the community and were not expected to result in charges which would, in the aggregate, exceed the amount that would have been charged if the physicians in the group had billed individually. The Regulations also recognized that for various reasons such a uniform schedule of charges might result in an attending physician charging different amounts for his services to teaching patients than for his services to his other patients. On this basis the Regulations stated that such charges should not be taken into account in determining the attending physician's reasonable charge for patients outside the teaching setting. On the other hand, the Regulations also indicated payment for the services of an attending physician in a teaching setting should be made in accordance with the same criteria for the determination of reasonable charges as are applicable to the services the physician renders to his other patients. Each of us who participated in the discussions on this matter arrived at our own interpretation of the various Intermediary Letters dealing with this subject, depending on our responsibilities as hospital administrator, teaching physician, or Carrier Representative.

The reasons for our agreement on developing a mutually acceptable uniform schedule of charges for services rendered in the teaching setting were that it would facilitate administration, preclude the payment of different amounts to the same physician rendering identical services in different teaching hospitals, and preclude payment of different amounts where one hospital might have an affiliation agreement with another hospital. It was also recognized that hospitals and their teaching staffs who proposed a schedule which was acceptable as equitable would abrogate that agreement as soon as it was learned that another hospital had negotiated a higher reimbursement rate. In fact, all of the hospitals with whom we have an agreement regarding reasonable and equitable charges in the teaching setting have indicated in writing that this agreement would be terminated if another hospital and its teaching staff received a higher reimbursement for these services.

It was finally agreed with those hospitals for whom cases are now being submitted to use the Relative Value Scale of the Medical Society of the State of New York with conversion factors of $7.00 for medical services and $5.50 for surgical serivces as the reimbursement for in-patient services. For out-patient clinic visits, it was agreed that the allowed charges would be $8.00 per visit for serivces rendered by a specialist and $6.00 for serivces rendered by a general practitioner. There is nothing sacred about the conversion factors or clinic rates. Many of us agree they are equitable at this time and that we should get the program on the road. They could change as conditions develop which affect the cost of medical care. Uniformity of reimbursement is a concept that you have to discuss more frankly with each other. If you want stability in the administration and continuing implementation of the program, I believe there must be uniformity of reimbursement.

Much emphasis was placed by SSA representatives on the requirement that reimbursement for services rendered by attending supervising physicians in the teaching setting must be for personal and identifiable services to the Medicare patient. The Regulations require that a physician in the teaching setting provide services of the same character in terms of the responsibilities to the patient

that he assumes and fulfills, as he would to his other paying patients in order for his charges to be recognized for payment. In our opinion, this indicates the need for actual personal care of the patient. Patients must be seen and examined, their charts and treatment personally reviewed by the attending physician, and the care rendered by the resident must be closely supervised.

In the case of major surgical procedures and other complex and dangerous procedures or situations, the physician's personal and identifiable service must include supervision in person during the performance of this procedure. There are varied interpretations as to whether this means the attending physician should be a part of the operating team, or only in the operating room for a few minutes while on his way to other duties, or supervising three operations simultaneously or available in the operating room during the course of the operation. In my opinion, the attending physician should be a part of the operating team but it is possible that his physical presence in the operating room during the time of surgery may be acceptable.

In our discussions with hospitals and their attending physicians with whom we have already implemented the billing procedure and reimbursement, there was agreement on certain ground rules. It was recognized that the number of days an attending in the teaching setting might see a Medicare beneficiary during a period of hospitalization might vary from hospital to hospital.

It was also recognized that the extent of pre- and post-operative surgical care rendered by an attending in the teaching setting might vary from hospital to hospital. It was agreed, therefore, that there should be sufficient notes in the hospital record signed by the attending physician on the medical service and by the attending surgeon for the pre- and post-operative surgical care to indicate personal involvement and personal responsibility by the attending in the patient's care. As I indicated, in my opinion, the attending should be a part of the operating team because in such a situation his name appears on the operation record. While the attending's physical presence in the operating room during the course of the operation may be acceptable, I feel there is a need to develop some mechanism to substantiate this in the interest of the hospital, its attending staff and the Carrier.

Where a physician performs services in the teaching setting as a Medicare patient's attending physician, Part B payments may be billed for by the physician or an organization of physicians or by the hospital or if the physician is a faculty member of a medical school, by the school. Where the hospital bills for the services, it should use the SSA 1554, even though the physician is not hospital based. The physician's authorization is required in writing to permit the hospital or any of the other organizations to bill on his behalf. The organization must provide the Carrier with the names of the physicians who have authorized the organizations to bill for them and must keep the Carrier informed of changes on a current basis.

If an entity other than the hospital bills, the SSA–1490 should be used and the requirements as stated also apply. If an individual physician bills on a 1490 for his services in the teaching setting, he must indicate the name of the hospital on the 1490 and he must indicate that the services were rendered in the teaching setting.

These SSA guidelines and the ground rules agreed upon in our discussions will govern reimbursement for services of attending physicians in the teaching setting. When billings are made, we will presuppose that care has been rendered in keeping with the regulations and ground rules and is substantiated by the hospital records. In some graduate medical education programs, and especially where services are rendered by five year residents, the attending may not be involved in rendering a personal and identifiable service to the Medicare patient. We have been assured that there will be no billing in these situations. United Medical Service as the Medicare Carrier has the responsibility for reimbursement in accordance with the Law, and such responsibility will require mechanisms for auditing. I am certain too, that auditing procedures will be carried out by the Department of Health, Education, and Welfare and the Government auditing Office. We feel that it is the hospital's and its attending staffs responsibility to submit requests for payment for services rendered in the manner outlined. UMS as the Carrier will assume, subject to verification, that they have been so rendered.

I believe that if we cooperate with each other in making these regulations and ground rules work that we have established a cause of action acceptable to the government and all the various publics. I am sure there will be many questions, I hope I can answer them to your satisfaction. Thank you . . .

APPENDIX A

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Greater New York Hospital Association

Statement of position re proposed AHS member hospital reimbursement formula dated December 5, 1969

Introduction

The transition to "cost controlled" and prospective reimbursement should not be as precipitate as outlined in the final draft of the proposed formula. The effective date of the formula should be as determined by the Commissioner and in no event earlier than January 1, 1971.

Section 101: Prospective Establishment of Final Payment Rates

This section provides that AHS payment rates be established on the basis of a broad averaging of all hospital costs. On the other hand, Medicare regulations provide that related payment rates be established on the basis of costs and patient days relating only to Medicare patients (The RCC Formula). The result of the Blue Cross approach is that the hospital would receive, in the aggregate, less than its reasonable cost. Accordingly, the AHS formula should be adjusted to compute rates on a basis which excludes cost incurred and the related number of inpatient hospital days care for Medicare beneficiaries.

Section 102: Selection of Appropriate Indices

The choice of the appropriate indices should not be left solely to the judgement of the AHS. Since the formula sets forth a role for the Hospital Advisory and Reimbursement Committee, this Committee should be jointly involved with AHS in determining appropriate indices Additionally, composition of this Committee should be indicated. If it is provided for in the AHS's By-laws, the pertinent By-laws section should be appended to the formula.

Section 104: Limitation Based on the Amount the Hospital Would Otherwise Charge for AHS Covered Services

This limitation puts the hospital in a position where it probably cannot recover its reasonable costs over any span of years. In one year if the hospital's costs exceed its billing rates it would recover only its billing rates, and yet in the next year if billing rates exceed costs it could only recover cost. It must be recognized that hospital administration can never guess precisely what its costs will be in order to establish similar billing rates. Therefore, this formula places the hospital in the position of routinely setting its billing rates at a substantially higher level than anticipated cost so that it may be in a position to recover cost. Accordingly, the patient who is not covered by Medicaid, Medicare or Blue Cross is penalized. The limitation of billing rates should therefore be deleted.

Section 301: Capital Cost in Voluntary Hospitals

The question of capital costs is not one of reimbursement philosophy but rather the institution's inherent right to be reimbursed for actual capital costs incurred in providing physical assets for use by Blue Cross subscriber patients.

A separate Greater New York Hospital Association position paper re depreciation as a capital cost factor is attached.

In connection with any requirement for funding of depreciation payments, it must be remembered that Alanson W. Willcox, General Counsel to the Social Security Administration—in testimony presented to the Senate Committee on Finance at its May 26, 1966 hearing— indicated that "The suggestion that payments on account of depreciation should be made only if the recipient undertakes to fund such payments, stands in quite different posture. The objection to this proposal is simply that the Secretary lacks authority to impose such a requirement. The statute directs him, unconditionally, to pay providers the reasonable cost of services to beneficiaries, and confers no authority to control the use that the providers may make of the proceeds. Section 1801, indeed, specifically forbids him to exercise any supervision or control over the administration or operation of a provider. He may do whatever he can to encourage the funding of depreciation payments, but it seems entirely clear that he could not legally withhold payments from an institution that declined to do so."

Additionally, the debt limit of 50% of the net book value is inconsistent with the necessary modernizations and improvements required in many voluntary hospitals. It is recommended that 50% "or as determined to be reasonable, considering the institution, the existing money market, and after consultation with the appropriate areawide planning agency" be substituted. It should be noted that many "Ghetto" hospitals which need extensive rebuilding and/or modernization, would not have an appreciable net book value applicable to existing buildings and fixed equipment.

Section 501: Utilization Incentive

The question of medical management and utilization review is one which cannot, per se, be solved through a reimbursement formula. The techniques necessary to produce any findings in this regard are at best rudimentary. Until they can be refined for application other than through reimbursement formulae, this entire section should be stricken.

Section 701: Amount of Community Service Factor

In view of the close relationship between the maintenance of outpatient clinics and medical education related to patient care services, the 5% limitation will not apply to hospitals having full time physicians serving as residents under an American Medical Association approved residency training program covering at least four clinical specialists, two of which must be internal medicine and surgery, or to hospitals having full time physicians serving as interns under an AMA approved internship training program.

Section 802: Expenses Not Covered—Educational Activities

Since the formula indicates that a program of education is only to be included if it efficiently meets a recognized community need, we believe that the determination of this need should be made jointly by AHS and the Hospital Advisory and Reimbursement Committee. We would also propose that the educational exclusions in Section 802 be defined as undergraduate medical education or graduate programs in the basic sciences.

Section 811: Expenses Covered—Interest Expense

To avoid confusion regarding hospital board members who might be officers of banks or other lending institutions, the words "or personal relationship to the borrowing organization," should be clarified particularly since a more favorable interest rate might result.

Section 814: Expenses Covered—Third Party Billing by Residents or Clinicians

Change to read as follows: "The expenses of physicians serving as full time residents or clinicians will be reduced by the amount of fees collected for professional services rendered by such physicians if such income is used for defraying general operating expenses of the hospital."

Section 815: Expenses Covered—Physicians Required by Statute

Change to read as follows: "Salaries and other payments to or on behalf of physicians who have responsibility for the training of interns and residents under programs approved by the American Medical Association will be included in the calculation of patient care operating costs.

In the absence of such approved programs, salaries and other payments to or on behalf of a medical administrative officer whose primary function is supervision of the resident physician staff will be included in the calculation of patient care operating costs.

Salaries and other payments to or on behalf of physicians whose employment is required by statute or governmental regulation as necessary to the operation of the institution will be included in the calculation of patient care operating expenses.

Salaries and other payments incurred for such purposes will be reduced by any fees collected by such physicians and turned over to the hospital for operating purposes."

Section 902: Definition by Accommodation

Since this formula attempts to partially recognize "community service" factors, we believe that a 90% weighting of ward patient days is required as a "community service" subsidy of hospitals' ward

service necessitated by the failure of state government to pay the full cost of services rendered to the medically indigent. In view of the requirement of Article 28 of the Public Health Law that reasonable cost will no longer be the basis for reimbursement of voluntary hospitals by state government, such subsidy appears to be justified and equitable under the "community service" concept.

Section 1402: Generally AcceptedAccounting Principles

We believe that the phrase "unless the requirements of the reimbursement formula indicate the need for a specific variation in such principles" should be deleted since it is not consistent with generally accepted accounting principles.

Section 1504: Hearing Procedure

This proposed formula mentions in a number of places that judgement is solely at the discretion of AHS. This is illogical. It must be recognized that this section does in no way foreclose the hospital's right to appeal to an authority beyond that of AHS.

General Comments

One of the greatest problems facing voluntary hospitals today is that of cash flow. Hospitals incur expenses in providing standby services and also expenses that can be related to the individual patient immediately upon his admission to the hospital. On the other hand, third party payers do not pay the hospital generally until some time following the patient's discharge and hospitals are therefore underwriting expenses that are a third party payers responsibility.

This problem of cash flow must be corrected. Third party payers including AHS must pay interest on those funds held which properly should have been paid out of voluntary hospitals.

Associated Hospital Service of New York

Reply to the Greater New York Hospital Association statement of position with respect to the New York Blue Cross member hospital reimbursement method effective January 1, 1970

Introduction

The effective date of the reimbursement method has been determined to be January 1, 1970.

Section 101: Prospective Establishment of Final Payment Rates

The discussion in this portion of the GNYHA position paper involves the relationship of the Blue Cross method of reimbursement to the Medicare method of reimbursement and, in effect, calls for a Medicare "carve-out".

We are opposed to the principle of "carve-out" simply because it provides a ready mechanism for a pass through of underfinancing by Medicare to Blue Cross. Thus, if Medicare introduced a restraint into the Medicare Principles of Reimbursement, the effect of the restraint would be lost because Blue Cross would be required to finance costs not covered by the Medicare program.

As an additional comment, we quote the following paragraph taken from page 116 of the Report of the Staff to the Committee on Finance of the United States Senate dated February 9, 1970:

"A serious conflict of interest situation is also created where Blue Cross plans, acting as subcontractors under the program, have a "carve-out" reimbursement arrangement with hospitals. Under this arrangement the Blue Cross subcontractor first determines the amount the hospital should be paid by medicare and then, based upon remaining costs, pays the hospital on behalf of its regular Blue Cross subscribers.

"There is, therefore, an incentive, in such cases, for the Blue Cross subcontractor to maximize the medicare payment since that procedure would reduce its own payments to a hospital."

Section 102: Selection of Appropriate Indices

We agree that the appropriate indices "should not be left solely to the judgment of AHS". We are presently working with Dr. Jules Backman, consultant to the Greater New York Hospital Association, on improvements and sophistication in the indices.

There is no reason why the AHS by-laws should be appended to the reimbursement method.

Section 104: Limitation Based on the Amount the Hospital Would Otherwise Charge for AHS Covered Services

The question of a limitation based on charges dates back to 1935 when Blue Cross first began to reimburse hospitals. Under the direc-

tion of the Superintendent of Insurance, and continued by all of his successors since 1963, AHS has maintained rates of payment not in excess of what the hospital would charge the general public.

It is difficult to conceive of any situation in which AHS would be able to persuade the Superintendent of Insurance to change this approach.

Section 301: Capital Cost in Voluntary Hospitals

A separate response to the Greater New York Hospital Association position paper with respect to depreciation will be prepared.

With respect to the requirement that depreciation be funded, the Blue Cross reimbursement method is consistent with the requirements of the New York State Principles of Reimbursement and the State Department of Health Regulations.

The comment made by GNYHA with respect to statements made by Alanson W. Willcox is not pertinent to the New York situation.

With respect to the debt limit of 50% of net book value, we are prepared to modify this position to reflect the Regulations issued by the New York State Department of Health under Article 28–B. It seems clear that a loan program can not be substituted for a grant program. Admittedly, the "ghetto" hospital needs capital financing desperately; however, it is this hospital which is unable to sustain a loan program.

We think that it would be more productive to promote capital grant programs for "ghetto" hospitals than to try to impose financial burdens on hospitals that can ill afford to carry them.

Section 501: Utilization Incentive

There is no possibility of striking out the utilization incentive provision. Admittedly, the present provision of the reimbursement method is unworkable and requires revision. The efforts of the GNYHA should be toward developing a workable, equitable provision and the AHS staff is prepared to cooperate with hospital representatives to this end.

Section 701: Amount of Community Service Factor

It seems clear that the community service factor included in the present Blue Cross reimbursement method is in direct conflict with the implementation of the Ghetto Medicine Act. Accordingly, a complete revision of the community service factor is in order. The AHS staff is prepared to work with hospital representatives on a revision of the community service factor. Hopefully, such revision would adequately compensate institutions in a manner equitable between institutions for services rendered to the community which, for one reason or another, may not be adequately financed by the community. Of course, we would expect to discuss the need and the scope of such services with the appropriate areawide planning council before developing implementation of a community service factor.

Section 802: Expenses Not Covered—Educational Activities

The question of whether or not an educational program efficiently meets a recognized community need contains within it elements of a much larger question, namely, the statutory requirement that Blue Cross rates of payment be reasonably related to the cost of efficient production of hospital services.

The manner of determining efficiency whether it be related to hospital services or educational programs is unsettled at the moment of this writing. We are prepared to discuss with hospital representatives an equitable and rational approach to this acute problem. Hopefully, such approach would take into consideration the opinion of the hospital, the opinion of the AHS staff and, most importantly, the opinion of the areawide planning council.

Sections 814 and 815

The Greater New York Hospital Association approach in both sections is to continue existing practices with respect to fees collected by salaried physicians. There is great and completely justifiable concern on the part of third party agencies over duplication and escalation of payments made to physicians for services that are presumably reimbursed as a hospital service. Particularly, it may be expected that in the very near future, the Social Security Administration will take radical steps to root out such duplication and escalation of payments. Anything included in a Blue Cross reimbursement method which would contribute to a continuance of existing practices could be embarrassing both to hospitals and Blue Cross.

Section 902: Definition by Accommodation

The suggestion to weight "ward" patient days at 90% is, in reality, an attempt to obtain a hidden plus factor for certain hospitals. Such plus factor is expressly forbidden by statute. In commenting on Section 701, a statement has been made that the AHS staff is prepared to work with hospital representatives on a revision of the community service factor.

Section 1402: Generally Accepted Accounting Principles

It seems unnecessary to point out that price-level determinations need not be consistent with "generally accepted accounting principles" either in the hospital industry or in any other industry in the United States.

Section 1504: Hearing Procedure

The actions and determinations of the AHS staff with respect to the establishment of the levels of payment rates to an individual hospital or to groups of hospitals are always subject to formal review. Such review is made for consistency in the method of reimbursement, equity to an individual institution, equity between institutions and equity to the Blue Cross subscriber.

General Comments

The AHS staff is in general agreement with the GNYHA comments and is presently working toward an equitable solution to this problem. However, any agreement by AHS to accelerate the flow of cash to hospitals must be accompanied by firm guarantees on the part of hospitals to maintain the flow of case reports to AHS.

Further, to the extent that an accelerated cash flow reduces an individual hospital's need for current indebtedness, consideration must be given to the allowability of current indebtedness interest expense.

Greater New York Hospital Association

Statement of position in connection with inclusion of depreciation as a cost factor in computing reimbursement payments to hospitals and the requirement for funding of related amounts

Question

A suggestion has been made that in the future that portion of the Blue Cross payment rate which relates to depreciation of buildings and fixed equipment be paid to hospitals only if they fund an amount equal to such factor and make expenditures from that fund after approval of the Regional Planning Council. It has further been suggested that in those cases where hospitals are unable to fund such amounts that such payments be made to a fund administered by trustees appointed by Associated Hospital Service of New York.

Position

Depreciation

Depreciation on buildings, fixed equipment and other equipment which is not charged to expense when purchased is an element of cost which must be considered in determining payment rates to nonprofit hospitals under service contracts with Blue Cross, Medicaid, Medicare or other third party payers. This has long been recognized in business circles as an element of cost and is also recognized by the Federal Government and the State Government.

Depreciation in these cases represents a write-off against an accounting period of a portion of the cost of related capital assets. This charge is intended to represent the value of such properties used during that accounting period in providing services and is similar to a write-off of prepaid insurance premiums or, indeed to a write-off of inventories used during an accounting period where the original expenditure has been set up as an asset. The write-off of assets is a responsibility of the trustees of nonprofit organizations.

The trustees of such organizations have a responsibility to protect their assets. These trustees would be negating their responsibilities were they knowingly to agree to sell these services at less than cost with the result that the assets of the organization would be dissipated.

Argument has been raised to the effect that Blue Cross or Government should control that portion of payment rates which represent depreciation in order to assure that related funds are available for replacement of facilities at a future date. This, however, is specious reasoning as this factor represents a cost which has been incurred—it deals with a past period.

The question of the continued existence of the organization represents an entirely separate problem which must be faced by its board of trustees at some future time. No nonprofit hospital is required by law to continue in existence and in fact the law of the State of New York provides that upon dissolution the net assets of such corporations be taken under control of the Secretary of the State of New York and distributed to other nonprofit organizations.

Funding

In a profit making organization revenues should be based on selling prices which yield costs including depreciation plus an element of profit. Theoretically this provides funds to the organizations to replace capital assets at a future date. Yet this ability to expend sums of money in the future for replacement of capital assets depends on cash flow and as a result many of these profit making organizations must rely on borrowings for such expenditures.

In nonprofit hospitals, at this point in time, the bulk of the service provided is paid for by third party payers at rates which at best represent an amount equal to cost. The hospital commences expenditures of funds for services immediately upon the admission of the patient. Billings for these services generally are made on the discharge of the patient and payment by the third party follows that by some period of time. It is true that advances may be made against amounts to be billed, at least in the cast of Medicare patients however, these advances are never equal to the total costs expended for services. Inasmuch as the hospital receives no profit it has no margin which it can set aside to provide for the funding of depreciation. That depreciation factor is needed for working cash. Further, the unstable situation as to Medicaid patients in the State of New York has caused—

(1) A substantial additional operating loss which was not anticipated, and

(2) A substantial stretching out of the payment period with an increase in the critical problem of cash flow.

Although this organization is in agreement with the principle of the funding of depreciation it must be recognized that this is a practical impossibility under present conditions.

A further question has been raised as to the logic of paying hospitals with very old fixed assets at a rate which includes a factor for depreciation. In such cases it must be recognized that if the fixed assets are still in use they obviously have some remaining useful life. It must also be recognized that these hospitals have not been fully reimbursed for the cost of these fixed assets by third party payers as Medicare and Medicaid are of recent vintage and Blue Cross has been on a cost reimbursement formula only since 1960.

Therefore these hospitals should be allowed to restate the carrying value of related assets based on their now estimated useful life and charge depreciation accordingly. In the event they are not in a position to do this it then appears entirely logical and proper to include in their payment rates a factor for depreciation based on a percentage of operating costs.

Summary

This association takes the position that depreciation of buildings and fixed equipment as well as depreciation on movable equipment represents a proper element of cost which must be paid to nonprofit hospitals by third party payers which take responsibility for the payment for service benefits to a group of beneficiaries.

That element of cost (depreciation) may be computed on the basis of records maintained by the hospital or by applying a percentage against operating costs. Further it is the position of this organization that no patient or third party agency has any legal right to restrict

to a hospital the way in which it shall account for payments received in reimbursement of costs for services rendered and therefore, funding of depreciation cannot be required, even though we as an association agree with the principle of funding.

Associated Hospital Service of New York

Statement of position in connection with the capital cost element in computing the level of reimbursement to hospitals

The Greater New York Hospital Association statement of position with respect to the inclusion of depreciation as a cost factor in computing reimbursement payments to hospitals serves as an excellent focal point for a comprehensive review of the capital cost element to be included in Blue Cross reimbursement methods.

The use of depreciation as an element of allowable cost in a third party reimbursement method has a number of flaws:

1. There is no known relationship between depreciation—computed on any basis known to man—and the capital needs of a given institution.
2. Depreciation is a proper cost in a non-profit organization only when accumulated earnings are utilized to acquire capital assets.
3. The payment of depreciation in the absence of severe restrictions as to the use of the cash generated by the inclusion of depreciation as a cost element creates doubt in the minds of the public as to the ultimate disposition of the monies.
4. The placing of restrictions on the use of cash generated by depreciation expense creates a severe drain on the working cash balance of an institution.
5. The inclusion of depreciation as an element of cost in reimbursement presumes that each brick in the institution will be replaced brick by brick and further assumes the continued existence of the institution in perpetuity.
6. The inclusion of depreciation as a cost element assumes that the governing board of an institution is the sole arbiter in any decisions concerning the acquisition of capital assets.

The difficulty in approaching the problem of capital needs of hospitals lies in two factors—an inability to view the problem as it pertains to all hospitals rather than just an individual institution and, the difficulty in divorcing oneself from past practices. It would appear that the following steps are a prerequisite to a determination of the capital needs and how they should be met:

1. A distinction should be made between short term and long term capital needs. Thus, the purchase of major movable equipment would be a short term capital need.
2. With respect to long term capital needs, a distinction should be made between immediate and future needs. For example, amortization of existing indebtedness is an immediate need; the desire to replace a building ten years from today is a future need.
3. A determination should be made of the appropriate role of the individual patient as opposed to the community at large in financing the capital needs of an institution.

4. As is required by statute in New York, substantial capital construction must be approved by the appropriate areawide planning agency.

Short term capital needs of an institution can readily be met through the use of depreciation on either a straight-line or an accelerated basis. In this instance, depreciation serves as a vehicle for spreading the cost of capital goods over their expected usefulness. It is a convenient method and reasonably practicable. It should be understood that its reasonability and practicability as a method is derived solely from the fact that it is applied to short term needs.

Within proper limits, the immediate long term needs of an institution should be met through patient care payments. Included in this category would be amortization of long term indebtedness and restoration of funds taken from accumulated earnings for the purchase of capital assests.

The idea of the use of "proper limits" for the determination of debt amortization is to draw a distinction between the capital financing required of the patient and the capital financing that should be drawn from the community. It seems manifestly unfair to compel the user of a facility to pay not only the cost of operating the facility but also the cost associated with providing the facility. If this principle were expanded to other areas of our economy, the subway rider would probably be paying 60 cents for a one way ride and, certainly, *all* roads would be toll roads; and, of course, school taxes would be an intolerable burden on taxpayers with children in the school system.

The AHS staff is of the firm opinion that the proper method for meeting the capital needs of hospitals is close to the one outlined in Section 301 of the reimbursement method effective January 1, 1970. Perhaps Section 301 should be modified to provide for the restoration of accumulated earnings used for capital improvements. Apart from this modification, Section 301 would appear to fully meet the immediate capital needs of member hospitals in an equitable manner.

The continuance of an option to permit funded depreciation will inevitably lead to three problems:

1. An accusation from less affluent institutions of discriminatory practices in favor of the more affluent.
2. A drain on operating cash of the institutions selecting Section 302.
3. An attempt to substitute questionable bookkeeping practices for actual funding by hospitals selecting Section 302.

Finally, the capital cost factor included in reimbursement must be recognized as a payment to meet the capital needs of the institution and not as a method of providing a "plus factor" to the hospital. For too long a period of time, hospitals have confused their capital needs with their operating needs. Some of the confusion resulted from desperation created by severe shortages of operating funds. In any case, there is a great need for clear thinking with a definition of the problems involved in both items. Lastly, there is a clear need for representatives of each institution to think in terms of the industry as a whole rather than in terms of the individual institution.

APPENDIX B

progress in prepayment

a summary of the pilot project designed to deliver quality medical care to the poor



Foundation for Medical Care
San Joaquin Medical Society
Stockton, California

MEDI-CAL PILOT PROJECT IN PREPAYMENT

. . . an introduction and brief summary

On February 5, 1969, the Health Review and Program Council of the State of California received a progress report on the San Joaquin Foundation for Medical Care Pilot Project. At that time the project was just one year old.

The presentation that follows is a transcription of the taped proceedings augmented by supportive information.

A one-year pilot program designed to improve quality medical care for the poor throughout California was initiated February 1, 1968, by the San Joaquin Medical Society's Foundation for Medical Care through a contract with the State of California Department of Health Care Services.

The prepayment program is being administered by the Foundation for Medical Care of the San Joaquin Medical Society, under a contract with the State Department of Health Care Services. The San Joaquin Medical Society covers the central California counties of Amador, Calaveras, San Joaquin and Tuolumne, with a combined population of approximately 342,000.

There are about 300 doctors in private practice in the four counties and 96 per cent of them are Foundation members. They have contracted through the Foundation under the new financing approach to provide all the medical services needed by almost 22,000 Medi-Cal recipients in their area for a year.

The Foundation's actuarial consultant developed a dues amount for prepayment coverage which was accepted by the State. Each month the State is billed this dues amount times the number of persons in the risk pool. This produces a monthly amount of money out of which physicians' services are paid. Reserves accumulated in any one month are carried over for future months.

Doctor Donald C. Harrington, president of the Foundation, points out that payments by the state are conservative and appear to be more than adequate to take care of physician fees. "As in most programs, a reserve is set up to take care of contingencies," Dr. Harrington comments.

The prepayment plan now embraces the nearly 22,000 welfare receipients in the four counties. Physicians receive usual, customary and reasonable fees that were extant at the time the program was underwritten.

Of the three recipient categories covered under the initial prepayment contract, the dues amount for the Aid to the Disabled has been fixed at $14.50 per person; for the Aid to the Blind at $12.25 per person; and for each person covered under the Aid to Families with Dependent Children, $6.25 per person. This created a pool of $165,000 for the first month of the program.

In discussing the project, Dr. Harrington sees many definite advantages and a real possibility for expansion of the prepayment program, both in services and to other areas of the state and nation.

"We are very excited about the prepayment concept and the fact that we are putting welfare recipients into insurance-type programs," says Dr. Harrington, continuing, "because this is a prepayment program, it is set up for the state to pay a certain amount monthly. This puts a predictable ceiling on costs for a predictable time."

Dr. Harrington continues, "All claims from all providers, including hospitals, nursing homes and pharmacies, flow through the Foundation office. This information is recorded on patient and provider profiles. Out of this we are developing review mechanisms which will guarantee good care and seek to eliminate under- and over-utilization.

In this experiment, the Foundation is attempting to make the prepayment project both expandable and transferable.

By making it expandable the project will eventually be able to include prepayment of hospital services, complete drug services and other medically related services.

It is being made transferable through a program of record-keeping so thoroughly detailed that other interested medical societies will be able to pursue similar-type programs without the necesssity of developing their own administrative mechanisms.

With the prepayment pilot project well underway, the Foundation is in the midst of exploring the possibility of proposing a prepayment program to the Federal government to cover those patients under Medicare.

"All of this interest and activity in Medi-Cal and Medicare by the San Joaquin Foundation fits into our original purpose and intent when we formed the Foundation in 1954," emphasizes Dr. Harrington, "and that is to attempt to stimulate prepayment programs for all segments of the population."

Foundations for Medical Care are active in 29 California counties. The United Foundations for Medical Care Service Corporation represents these foundations, which include over 6,000 physicians.

The United Foundations have passed a resolution expressing interest in the San Joaquin prepayment program and stated in the resolution that if the program is successful, most of the other Foundations in California will be interested in following suit.

Most of the clerking functions connected with the prepayment program are carried on through a separate contract between the fiscal intermediaries in California, specifically Blue Cross North and South, California Blue Shield, the State Department of Health Care Services and the San Joaquin Foundation.

County welfare departments have the responsibility of determining eligibility for the program and of keeping the Foundation up-to-date on eligible recipients.

Once public assistance recipients are certified by category each month the State pays the Foundation on a monthly basis within the framework of Medi-Cal fiscal regulations.

Dr. Harrington concludes: "Our pilot program utilizes the fee system for physicians which prevails in private practice and should almost surely be acceptable to most physicians throughout the country."

PURPOSE OF THE PROJECT

By Vic Boisseree
Project Coordinator
Department of Health Care Services

This project is the first experimental proposal the Department has entered into in order to check various alternate methods in the delivery of health services as well as different methods of administering the program.

The San Joaquin project was designed to test the feasibility of prepayment in a Title XIX medical program. The risk attendant to such a method was to be borne by the physician members of the Foundation with them underwriting the project. The dues structure (premium) mutually agreed to by the Foundation and the Department was based on all information we had available regarding utilization and costs in 1967 and early 1968.

It was realized then that this dues determination was probably so calculated as to provide the incentive to the physicians to be efficient as a group, yet not expose them to any severe financial loss. Coupled with prepayment came changes in administrative areas to allow the Foundation to exercise efficient control of the project.

In order to coordinate all of these changes contractual arrangements were entered into between the Department of Health Care Services and the San Joaquin Foundation. In addition, the fiscal intermediaries, California Blue Shield and Blue Cross North, were involved in integrating this project into the outgoing programs.

Our contract with the Foundation provides that they pay for all physician services rendered to cash-grant recipients of the four-county area of Amador, Calaveras, San Joaquin and Tuolumne. It does not cover payments for these services rendered to the O.A.S. category nor to the medically needy.

In order to determine the eligibility of the recipient we established a separate eligibility file on all San Joaquin project recipients at the Foundation. Because of this arrangement several changes in the California Blue Shield and Blue Cross North procedures were instituted.

All claims originating with providers in the four counties and for recipients residing in these counties could be verified for eligibility at the Foundation. This process was accomplished within 24 hours after receipt of the claim. The eligibility verification is for all providers, not just the physician. Currently eligibility is being determined by use of the multiple identification card system.

Claims of all providers are subjected to claims review and become part of the patient profile. To assess the quality of care being provided, the Foundation has developed and has now expanded its individual patient profile tapes to correlate all medical care received by the recipients. This intense local review utilizing local practitioners was the second object that was to be attempted in this project.

From this point the claim, having been reviewed for eligibility, completeness and utilization, is sent to the fiscal intermediary for payment. Claims for services for any care rendered to a recipient of the aforesaid counties sent directly to Blue Shield is returned to the Foundation for audit, posting, profile and payment, if covered within the physician service contract. Thus the San Joaquin County recipients obtaining physician services in Los Angeles would have their bill returned by Blue Shield to the San Joaquin Foundation for payment.

The Role of the Consultant

By John I. Morozumi, M.D.
San Joaquin County

When the San Joaquin Medical Society's Foundation for Medical Care undertook the Medi-Cal Project, we assumed the responsibility of providing medical consultation for those services which require prior authorization.

Our program retained the services of those consultants who previously had functioned in similar capacities for the welfare department, and added practicing physicians where needed. This is true in all areas except dental care, which remains as it was previously.

The chief Medi-Cal consultant coordinates the prior authorization review function of the specialized consultants such as ophthalmologists, optometrists, orthopedists, and otologists. The chief Medi-Cal consultant reviews all requests for extra-formulary drug exceptions, assistive devices such as wheelchairs, walkers, lifts, breathing machines, special duty nursing, medical transportation, physiotherapy, cosmetic surgery, and psychiatric services. In addition, all requests for placement in nursing homes or continued stay or transfers to other nursing homes are reviewed.

In each instance, authorization is granted or rejected in accordance with established policies and guidelines of the Department of Health Care Services. In the mountain counties we assign the responsibility to local consultants except for eye appliances and hearing aids. In all instances, when the remote Medi-Cal consultants requested assistance in determining the appropriateness of requested services, the chief Medi-Cal consultant at the Foundation office rendered his opinion.

The Medi-Cal consulant also participates in the Medical review deliberations and brings to that committee information regarding provider activities. He also utilizes patient profile information to assist social workers in extending social servicing to individuals and families.

For example, the social worker is our contact with patients who over-utilize by doctor shopping.

Excessive use of drugs becomes a real problem when a person is being prescribed for by two or more physicians.

Despite the separation of the Medi-Cal consultant role from the Welfare Department, valuable information is available at the welfare department. We do not hesitate to utilize social workers to obtain social information which is often extremely valuable in judging the appropriateness of nursing home placement, for instance.

We cannot over-emphasize the value of team effort between our project and the Welfare Department. In addition, we utilize the public health nurse from our health department, which also is a certified home health agency, to coordinate patient care.

In this regard we recognize a need to implement a coordinated discharge planning of patients coming out of hospitals into extended care facilities, nursing homes, and board and care home situations. We feel that a well-integrated and locally-administered program is the only way in which resources peculiar to each locality can be utilized to the fullest. It would seem that this could well be of great interest and value to comprehensive health planning.

The Medi-Cal consultant's role is judgmental and differs from the roles that peer review physicians play only in the matter of content. He applies the unique knowledge and experience that he has accumulated regarding the activities and levels of competence of numerous providers of services. He then adds to this knowledge vital social intelligence on file or obtained specifically for us by the welfare department to arrive at a reasonable judgment.

In the area of physician services, the review committees for the Foundation are reviewing and approving or denying payment for services after the care has been rendered based upon the diagnosis and appropiateness of treatment. In the area of prior authorization, the Medi-Cal consultant reviews prior to rendering of services. This has been found to be costly but extraordinarily valuable and necessary because there is a greater variability in the experience and competence of those physicians who originate services which are presently under prior authorization.

Until physician originators of special services learn to properly use services covered under prior authorization requirements, I believe that such requirements must not only be retained but broadened and strengthend. We must recognize that when a third party such as government "with unlimited resources" is paying the bill, many individuals become less careful and less conservative.

Some physicians must learn to use newer equipment and methods of treatment such as breathing machines. He must learn more of community resources to make reasonable judgements regarding medical transportations or institutional placements. He must learn when and how to use physical therapy and he must know of its limitations in certain disease states.

Obviously, this presentation is too brief to cover the specifics of problems and methods for solution. The emphasis of the role of Medi-Cal consultant is that local knowledge is vital if he is to function effectively.

Additional Comments by Donald C. Harrington, M.D., President, San Joaquin Foundation for Medical Care

I think what Dr. Morozumi has pointed out really are problems that are State-wide in the prior authorization system. I think that what is of importance here is twofold.

One, the integral relationship between the doctor that is doing the consultation work with our review committee and our medical profile structures, and two, the relationship of the Foundation review mechanisms to the Welfare Department. I think this is something that is extremely important.

How the Medi-Cal Consultant Concept Helps Insure Quality Medical Care

By John I. Morozumi, M.D.
San Joaquin County

We attempt to re-evaluate our consultant approach as new information and knowledge is developed. In the area of optics and visual appliances, we have a practicing ophthalmologist and practicing optometrist working together as a team. The ophthalmologist reviews M.D. requests for eye appliances and the optometrist reviews optometric claims.

When there are any questions they get together and discuss the matter. The regulations and guidelines have been especially silent in the area of the specifics of prior-authorization requirements. Therefore, the Foundation project, acting within the confines of the regulation, has implemented specific restrictions in allowable and non-allowable services. We have enjoyed excellent cooperation on the part of practitioners in our area.

There is one area, however, that remains untouched. When a prescription is authorized, does the recipient receive the glasses that were authorized? Kern County found in the past that periodic examination of the prescribed lense is important.

We also feel that we would like to use this innovative technique. Our optometric and ophthalmolgic consultants suggest that one eye-glass out of ten should be sent to an unbiased laboratory not located in our area. They would examine the lense to see if it corresponds to the prescription. The cost is estimated to be approximately one dollar per examination.

Hearing aids have been a greater problem, primarily because initially there was a great deal of pressure from the hearing aid industry directed toward recipients. Recipients were contacted by phone under a certain guise by some dealers who then invited the recipient to come to the hearing dealer's business establishment for test and fitting.

We have retained as a special consultant an otologist who restricts his practice to diseases of the ear only. The E.N.T. specialist in general examines these patients to certify that there is no medical contra-indication to the use of a hearing aid. Following this, the recipient is fitted with a hearing aid by the dealer. Then the patient is given an appointment with the otologist to make sure that the patient can use the device and is benefited. This is determined by special tests that he conducts.

Regardless of the degree of original hearing loss, however, I think that we have to be very careful that the patient who has the device is significantly benefited by the hearing aid. This means the attainment of some degree of effective hearing. We have requested of social workers follow-up information to ascertain that the recipient is indeed using the aid.

Prior to the inception of the Medi-Cal project a social worker was sent out from the Welfare Department in each case. We discovered that in too many instances the hearing aid was not being used shortly after the patient had received it. I don't believe that this is as much a problem now as it was in the past. We are making more accurate determinations in the mechanics of hearing aid dispensing.

There is an area of great problem in nursing homes and in the form MC170 which is the prior-authorization form for nursing home placement. The Medi-Cal consultant has the responsibility to determine that the placement is appropriate and that the treatment being given the patient is adequate. I emphasize this because the certifying agencies have no involvement or responsibility in the aforementioned areas.

I believe that patient care is the key point. The certifying agency utilizes lay people who really are not in any position to make medical judgment. The sheer volume of paper work by nursing homes and physicians has led to inaccurate and inadequate information having been given on such forms. To exercise medical judgment based on information on pieces of paper is, in effect, rubber-stamping.

In our pilot project we attempt to correlate the information on this form with on-the-site information regarding the patient's condition and care being rendered. The Medi-Cal consultant periodically makes personal visits to nursing homes to review charts and patients. This is time consuming.

We should explore alternative methods of checking on the accuracy of information contained on MC170's. We need to make more use of social welfare workers going into nursing homes. It is unfortunate, but true, that when a welfare recipient enters a nursing home, the case is not carried in the active ongoing case work file. We need to develop a new kind of personnel. For example, nurses with public health degrees and with public health backgrounds to substitute for the medical consultant's personal visits. This, of course, does not release the medical consultant from responsibility for periodic visits himself.

By including welfare workers, public health nurses, and the medical consultant, we can truly effect a medical-social review team concept. This concept existed briefly when the State Department of Welfare used to retain regulatory control over the medical program. This special way of looking into appropriate placement and adequacy of care of patients in nursing homes has been dropped and I believe this to be unfortunate.

In the area of psychiatry and cosmetic surgery, we don't really have many problems. I do wonder, however, about under-utilization of psychiatric services.

Physical therapy is constantly a problem. I focus upon some of these areas because the Medi-Cal consultant has to get himself involved in directly guiding, not just authorizing, patient care. Some have felt that administrative personnel (the Medi-Cal consultant) cannot function in guiding physical therapy. I disagree.

I am going to continue to come back to the Welfare Department where there is a fund of information available. For instance, in physical therapy I would see a request for physical therapy and I would wonder about it. The first thing I do is to find out if this individual ever received treatment in a rehabilitation facility or if he was included in the Functional Improvement Program (FIP) which was in effect at the Wel-

fare Department until two years ago.

Quite often we discover that an individual has already received maximum benefit. When an attending physician is not aware of this, we bring it to his attention. The attending physician is frequently under pressure by family and occasionally by traveling physiotherapists to resume treatment of physical therapy for permanent and static conditions.

A personal contact between the consultant and attending physicians has been quite helpful. Occasionally we identify situations of under-utilization. Patients who have recently sustained a stroke and who are not receiving physical therapy are occasionally identified. Some of these people can be sufficiently rehabilitated by physical therapy so that they can leave a nursing home.

For example, a request for nursing home placement is made for a 55-year-old male. By collecting and evaluating medical and social information we learn that the patient had a stroke within the week. He was placed in a nursing home and had not received physical therapy. I would, in such instances, call the physician and ask him to consider physical therapy. Although it does not always work and we don't always attain rehabilitation, I believe that we must attempt to do so.

For assistive devices the information commonly given on the request form is almost always insufficient. We rely heavily upon social information even where wheel-chairs and walkers are involved. From time to time we have noted serious over-utilization of oxygen and we have identified patients who need to be placed on IPPB breathing machines.

On the other side of the coin, we have seen the problem of the excessive use of such a device. In instances where a patient is using a breathing machine excessively to the detriment of his health, we bring this to the attention of the attending doctor.

An example would be a recent case I reviewed. This was a nine year old child who was using a breathing machine. The local Medi-Cal consultant who knows the physicians of his community and has a cordial relationship could suggest that a consultation is in order. I have gone as far as to arrange such a consultation with a specialist in order to assist the attending doctor, who is in a horrible bind and who does not know what to do with a nine year old asthmatic child wedded to a machine.

Patients with clinical problems have been identified by means of prior-authorization mechanics. It has really been an eye-opener. We don't mind the inconvenience of prior-authorization although it is sometimes cumbersome and occasionally aggravating. I believe that the proper use of the prior-authorization regulation with local knowledge and local contact between the Medi-Cal consultant and his practicing colleagues is an extraordinarily valuable mechanism to insure quality medical care.

REVIEW CRITERIA AND METHODS OF REVIEW

By Donald C. Harrington, M.D.
President, San Joaquin Foundation
for Medical Care

MEDICAL, SURGICAL, HOSPITAL AND DRUG REVIEW CRITERIA

The following documents outline the review criteria that are being used at the present time by our claims examiners. The claims that pass these criteria are immediately processed for inclusion in our data bank, and for payment. Those that do not pass the criteria are referred to the Medical Review Department. The procedures used by this department will be described later in this report.

The following criteria for the evaluation of medical care reflect the professional opinion of physicians in the area served by the San Joaquin Foundation for Medical Care. In all of these criteria, hospitalization and complicating factors have been excluded as not being within the scope of this study. In the development of these criteria, the costs of medical care have not been allowed to compromise medical judgment.

It is recognized that further changes in medical knowledge and available medical resources may necessitate changes in these criteria. It is assumed that an adequate medical history and physical is performed for each diagnosis. It must be recognized that other factors may affect the patient's recovery, such as:

Litigation (compensation).

Responsibility of the costs of medical care (either personal or third party).

Presence of concurrent disease including psychiatric disorders.

The judgment of the attending physician, based on a rational approach at the time, must be recognized. Obviously then, there will be medically justifiable deviations from these criteria.

CRITERIA FOR THE EVALUATION OF THE QUALITY OF MEDICAL CARE IN THE AREA SERVED BY THE SAN JOAQUIN FOUNDATION FOR MEDICAL CARE

Manual Page No.	Diagnoses:
12	Anemias
3	Arteriosclerotic and Degenerative Heart Disease
19	Arthritis and Spondylitis
21	Asthma
14	Bronchitis, Chronic and Unqualified
24	Bursitis, Synovitis, and Tenosynovitis
13	Colitis, except Diarrheo of Newborn
8	Diabetes Mellitus
17	Foreign body entering thru orifice
13	Gastro-enteritis
20	Hayfever
15	Hypertension with Heart Disease
4	Hypertension without mention of Heart
10	Infections of Skin and Subcutaneous Tissue
7	Lacerations and Open wounds
18	Menopausal Symptoms
23	Menstrual Disorders
16	Neoplasms, Benign or of Unspecified Nature
9	Obesity, not specified as of Endocrine Origin
11	Otitis Media
2	Prenatal Care (without abnormal conditions)
5	Psychoneuroses and Disorders of Personality
26	Rheumatism, Muscular or Unspecified
6	Sprains and Strains of Joints and Adjacent Muscles
25	Ulcer of Duodenum
1	Upper Respiratory Infections, Acute
22	Vascular Lesions affecting Central Nervous System
	Eye Refractions, over once every 12 to 18 months.
	Glaucoma, over once every 3 months.
	Slit Lamp and Fundus Under Dilation, over once every 6 months.
	Visual Fields, over 3 to 6 months.
	Conditions Not Covered Above, over 2 visits per month.
	Basic Chemistry Laboratory Group (itemize procedures)
	Physiotherapy, over 16 treatments.
	Intermittent Positive Pressure (IPPB), over 2 weeks.
	X-Ray and Laboratory Procedures, not related to diagnosis.

Medical Review Criteria — Out-patient Visits — Long-term Care After Initial Workup

DIAGNOSES—NUMBER AND FREQUENCY OF OFFICE VISITS	Refer to Manual Page
ANEMIAS — Work-up plus two visits during first week, then once a month on Primary, and as needed to clear up cause on Secondary.	12
ARTERIOSCLEROTIC HEART DISEASE — First week, up to three times; Second week, up to two times; Third week, once; Thereafter, one to two times per month.	3
ARTHRITIS AND SPONDYLITIS — Once a week for three weeks, then once a month for six months.	19
ASTHMA — Office or home. Acute cases, two to four times per attack. Visits may be daily. Three times a week for four months for desensitizing the chronic, then once every three to four weeks. Doctor must be present at desensitizations.	21
CHRONIC BRONCHITIS — Every two to three days.	14
BURSITIS, SYNOVITIS, AND TENOSYNOVITIS — Daily for two to four visits, then, depending on response, up to once a week.	24
COLITIS — SEE PAGE	13
DIABETES MELLITUS — Three visits during the first week, then once a week, for a month, then up to once a month. One visit allowed for insulin instruction.	8
FOREIGN BODY — First visit, then in day or two, then in a week.	17
GASTRO-ENTERITIS — SEE PAGE	13
HAY FEVER — Office. Two to four times for acute cases. Three times a week for four months for desensitizing the chronic, then once every three to four weeks. Doctor must be present at desensitizations.	20
HYPERTENSION WITH HEART DISEASE — Every day for three to four days, then once a week for a month, then once or twice a month.	15
HYPERTENSION WITHOUT MENTION OF HEART DISEASE — SEE PAGE	4
INFECTION OF SKIN — For cases with no complications, two visits plus or minus one, if surgery is performed, add one to two visits. Complicated cases (acne, carbuncle, cellutitis, impetigo, syphilis) will require more treatment consistent with diagnosis.	10
LACERATIONS — First day, fourth day, seventh day, fourteenth day.	7
MENOPAUSAL SYNDROME — Office or home. No hospital. To diagnose, two visits plus or minus one, then once a month for two to three months, then once every three months.	18
MENSTRUAL DISORDERS — SEE PAGE	23
NEOPLASMS, BENIGN — SEE PAGE	16
OBESITY — Two visits in first week, then in two weeks, then one a month for six to eight months.	9
OTITIS MEDIA — Varies depending upon whether it is purulent or catarrhal. Once a day for three days, then every two to three days for two weeks.	11
PRE-NATAL — Every three or four weeks up until the last two months, every two weeks for the next to last month, and every week for the last month.	2
PSYCHONEUROSES — One visit a week for three weeks. Treatment may or may not continue.	5
RHEUMATISM — One visit to diagnose, then once a week for four weeks, then depends on response. Office or home.	26
SPRAINS AND STRAINS — SEE PAGE	6
ULCER OF DUODENUM — Initially, two times plus or minus one during first week, then in two weeks, then in six weeks (for x-ray), then once or twice a month.	25
UPPER RESPIRATORY INFECTION — Three to four days apart.	1
VASCULAR LESIONS AFFECTING CENTRAL NERVOUS SYSTEM — At least once a day until acuity recedes, then at least once a month.	22
EYE REFRACTIONS — Over once every 12 to 18 months.	
GLAUCOMA — Over once every 3 months.	
SLIT LAMP AND FUNDUS UNDER DILATION — Over once every 6 months.	
VISUAL FIELDS — Over 3 to 6 months.	
CONDITIONS NOT COVERED ABOVE — Over 2 visits per month.	
BASIC CHEMISTRY LABORATORY GROUP (Itemize procedures)	
PHYSIOTHERAPY — Over 16 treatments.	
INTERMITTENT POSITIVE PRESSURE (IPPB) — Over 2 weeks.	
X-RAY AND LABORATORY PROCEDURES — Not related to diagnosis.	

Hospitalization Review Criteria

A & P Repair Without Hysterectomy — Over 5 days	Exploratory Laparotomy — Over 8 days	Splenectomy — Over 10 days
Amputation — Over 10 days	Fractured Hip — Over 21 days	Submucous Resection — Over 2 days
Appendectomy — Over 4 days	Gastric Resection — Over 10 days	Sympathectomy — Over 5 days
Bartholin Cyst — Over 2 days	Hemorrhoidectomy — Over 5 days	Thoractomy — Over 10 days
Breast Biopsy — Over 3 days	Hernia — Over 6 days	Tonsillectomy & Adenoidectomy — Over 2 days
Bronchoscopy — Over 1 day	Hysterectomy — Over 8 days	Thromboendarterectomy, Aneurysms, etc. — Over 18 days
Cesarean Section — Over 7 days	Laryngectomy With Or Without Dissection — Over 7 days	Thyroidectomy — Over 4 days
Cholecystectomy — Over 10 days	Nephrectomy — Over 10 days	Tur—Prostatectomy — Over 10 days
Colectomy — Over 10 days	Orchidectomy, Simple — Over 3 days	Ureterolithotomy — Over 10 days
Cystectomy — Over 14 days	Ovarian Cyst — Over 5 days	Vagotomy and Pyloroplasty — Over 10 days
D & C Including Cold Cone — Over 2 days	Simple & Radical Mastectomy — Over 6 days	Vein Ligations — Over 5 days
Esophagectomy — Over 14 days		

EXAMPLE CASE No. 1

DIAGNOSIS
Acute upper respiratory infection in the absence of a complicating factor.
VISITS
Either home or office, preferably office.
NUMBER OF VISITS
Between 2 and 4, or 1 and a phone call.
FREQUENCY OF VISITS
Three to four days apart.
LAB & X-RAY
Seldom. X-ray of chest when complications are present. WBC and differential may be indicated. Culture may be indicated.
THERAPY
Analgesics, sedatives, anti-tussives, expectorants, anti-histamines, and chemotherapy.
DURATION
Seven to ten days.

EXAMPLE CASE No. 2

DIAGNOSIS
Pregnancy, routine pre-natal care.
VISITS
Office.
NUMBER & FREQUENCY OF VISITS
Every three or four weeks up until the last two months, every two weeks for the next to last month, and every week for the last month.
LAB & X-RAY
Prenatal blood count, RH typing, blood typing, Wasserman, complete urinalysis; X-ray, pelvimetry, when indicated.
THERAPY
Prenatal supplements, anti-emetics, anti-nauseants, sedatives, and tranquilizers.
DURATION
Usually nine months.
NOTE:
Complicating factors would require separate diagnosis, and separate criteria of treatment.

EXAMPLE CASE No. 3

DIAGNOSIS
Arteriosclerotic and degenerative heart disease including coronary and congestive heart failure.
VISITS
Office or Home.
NUMBER & FREQUENCY OF VISITS
First week, up to three times. Second week, up to two times. Third week, once. Thereafter, one to two times per month.
LAB & X-RAY
Chest x-ray, urinalysis, CBC, Sed. Rate. No objection to cholesterol. EKG may be repeated every six months if there are no complications.
THERAPY
Analgesics, sedatives, tranquilizers, narcotics, digitalis, anti-coagulants, coronary vaso-dilators, anti-hypertensives, vaso-pressers, and anti-arrythymatics. On ambulatory patient, except where specific reason is stated, medications should be orally.
DURATION
Chronic—constant care.
COMMENT
When possible, medication given continuously should generally be given by the patient or the patient's family under the general supervision of the physician, (e.g. Heparin).

EXAMPLE CASE No. 4

DIAGNOSIS
Hypertension without mention of heart disease based upon more than one elevated blood pressure reading.
COMMENTS
This is often a catchall diagnosis. A thorough diagnostic work-up is needed to confirm this diagnosis, inasmuch as it is only a clinical finding, not a disease entity.
VISITS
Office only.
FREQUENCY
Initial diagnostic work-up plus one or two visits during the first week. No more than once a month thereafter, except in severe cases, then 2 to 3 times a month.
LAB & X-RAY
Urinalysis, CBC, EKG, chest x-ray, renal function tests (NPN, PSP, IVP, concentration tests, etc.), fluoroscopy permissible. Serum electrolytes.
THERAPY
Sedatives, tranquilizers, and anti-hypertensives.
DURATION
Chronic.

EXAMPLE CASE No. 5

DIAGNOSIS
Psychoneurosis and personality disorders.
COMMENT
Cases of this category are underreported. It is the unanimous desire of this committee that physicians should report this diagnosis. Usually this diagnosis cannot be made upon one visit. Since this may affect different systems, a complete history and physical is necessary to rule out organic disease. If indicated, a complete neurological work-up (with skull studies) may be done.
VISITS
One visit a week for three weeks. Treatment may or may not continue.
LAB & X-RAY
As needed to rule out organic disease in system of symptomatic referral.
THERAPY
Sedatives, tranquilizers, anti-depressants, and psychotherapeutic measures. Injections are rarely indicated and contra-indicated chronically.

EXAMPLE CASE No. 6

DIAGNOSIS
Sprain and strain, joints and muscles.
VISITS
Office.
NUMBER & FREQUENCY OF VISITS
Range from 2 visits (for an uncomplicated finger or toe) to daily for a week, then 2 to 3 times a week for 2 or 3 weeks, then every ten days until recovery on the complex cases.
LAB & X-RAY
No lab. X-ray of the joint involved, comparison films of opposite bones and joint where indicated.
THERAPY
Analgesics, sedatives, support strappings, muscle relaxants, local injection of anaesthetics, intrasynovial injection of steroids, aspiration, casts, and physiotherapy.
DURATION
Two weeks up a year or two, depending on severity.

EXAMPLE CASE No. 7

DIAGNOSIS
Lacerations and open wounds.
VISITS
Office, outpatient hospital care.
NUMBER OF VISITS
2 to 4 unless complicated.
FREQUENCY OF VISITS
First day, fourth day, seventh day, and fourteenth day.
LAB & X-RAY
No lab. X-ray only if foreign body.
THERAPY
Analgesics, surgical toilet, prophylaxis for tetanus gas, and chemotherapy.
DURATION
One to two weeks.

EXAMPLE CASE No. 8

DIAGNOSIS
Diabetes Mellitus

COMMENTS
This disease will be treated in two different ways, depending upon whether it is Acetone prone or Acetone resistant. It is recommended that this distinction be made as part of the diagnosis.
VISITS
Office. No hospitalization without other complications.
NUMBER & FREQUENCY OF VISITS
Three visits during the first week, then once a week for a month, then up to once a month. One visit allowed for insulin instruction.
LAB & X-RAY
CBC, urinalysis, post prandial blood sugar, fasting blood sugar, often an EKG, particularly on elderly, glucose tolerance test permissible. On a yearly basis, there should be a chest x-ray (for TB), and an eye exam, (always the eye exam on Acetone prone).
THERAPY
Insulin, anti-diabetic oral agents, and diet.
DURATION
Lifetime.

EXAMPLE CASE No. 9

DIAGNOSIS
Obesity.
VISITS
Office.
NUMBER & FREQUENCY OF VISITS
Two visits in first week, then in two weeks, then one a month for six to eight months.
LAB & X-RAY
CBC, urinalysis, PBI or BMR. Not necessarily any x-ray. Hormone assays rarely (i.e. Cushings).
THERAPY
Exercise, diet, anorectics, diuretics, thyroid, and psychotherapy.
DURATION
Chronic and recurrent.
COMMENT
Often psychogenic.

EXAMPLE CASE No. 10

DIAGNOSIS
Infection of skin and subcutaneous tissue.
VISITS
Office.
NUMBER & FREQUENCY
For cases with no complications, two visits plus or minus one, if surgery is performed, add one to two visits. Complicated cases (acne, carbuncle, cellulitus, impetigo, syphilis) will require more treatment consistent with diagnosis.
LAB
None without complications. Sometimes a CBC, urinalysis, or white count.
X-RAY
None.
THERAPY
Sedatives, analgesics, chemotherapy by mouth or parenterally, rarely therapeutic x-ray, topical medication, incision and drainage.
DURATION
Ten days, except chronic which may last six months to a year.

EXAMPLE CASE No. 11

DIAGNOSIS
Otitis Media.
COMMENT
Mastoiditis is rare. It requires explanation as a complication. It is, therefore, excluded.
VISITS
Home or office.
NUMBER & FREQUENCY OF VISITS
Varies depending upon whether it is purulent or catarrhal. Once a day for three days, then every two to three days for two weeks.
LAB & X-RAY
No, except in case of suspected mastoid.
THERAPY
Analgesics, sedatives, chemotherapy, topical softening agents, nasal vaso-dilators, and myringotomy.
DURATION
Ten days.

EXAMPLE CASE No. 12

DIAGNOSIS
Anemia.
VISITS
Office.
NUMBER & FREQUENCY OF VISITS
Work-up plus two visits during first week, then once a month on primary, and as needed to clear up cause on secondary.
LAB
CBC, urine for HCL, occult blood, bone marrow, wintrobe indices, other blood studies as needed, i.e. sickle cell, corpuscular fragility, gastric analysis. Serum iron if multiple occult blood is found.
X-RAY
If multiple occult blood is found, G. I. plus barium enema, G. U. tract, small bowel series, and chest x-ray.
THERAPY
B-12, folic acid, iron, and diet.
DURATION
Primary anemia: once a month for life. Secondary: until cause is cleared up.
COMMENT
When possible, medication given continuously should generally be given by the patient or the patient's family under the general supervision of the physician, e.g. B-12.

EXAMPLE CASE No. 13

DIAGNOSIS
Gastro-enteritis and Colitis.
(A)
Mild.
VISITS
Office, home occasionally.
NUMBER OF VISITS
One or two.
FREQUENCY OF VISITS
Every three days.
LAB & X-RAY
Stool culture and examination for ova and parasites.
DURATION
Three to five days.
(B)
Acute.
VISITS
Office, phone or home.
FREQUENCY OF VISITS
Every three days.
LAB & X-RAY
Stool culture and examination for ova and parasites.
DURATION
Three to five days.
(C)
Chronic.
VISITS
Office, home, definitely a complete work-up.
NUMBER & FREQUENCY OF VISITS
Once or twice a month for duration.
LAB
CBC, urine, stool culture, examination for ova and parasites, gastric analysis, malabsorption studies.
X-RAY
Barium enema, G. I. small bowel series.
DURATION
Depends on cause. Up to several months, or if psychogenic or ulcerative, much longer.
THERAPY
Sedatives, analgesics, anti-diarrhetics, hypodermoclyses, and anti-emetics. Chemotherapy when indicated.

EXAMPLE CASE No. 14

DIAGNOSIS
Bronchitis, chronic and unqualified and, Bronchitis, acute.
VISITS
Home, office.
(A)
Acute.
NUMBER OF VISITS
2 or 3.
FREQUENCY
Every two to three days.
LAB
W. B. C., and differential permissible.
X-RAY
Chest x-ray is not out of order.
THERAPY
Anti-spasmodics, anti-tussives, anti-histamines, analgesics, sedatives, intermittent positive pressure, chemotherapy, and abstinence from tobacco.
DURATION
7 days.
(B)
Chronic.
VISITS
An initial work-up plus two to six visits for each exacerbation.
LAB
Gram stain, sputum culture, CBC, urinalysis, pulmonary function tests if emphysema, and sensitivities.
X-RAY
Chest x-ray.
THERAPY
Anti-spasmodics, anti-tussives, anti-histamines, analgesics, sedatives, intermittent positive pressure, chemotherapy, and abstinence from tobacco.
DURATION
Up to life.

EXAMPLE CASE No. 15

DIAGNOSIS
Hypertension with heart disease.
VISITS
Office.
FREQUENCY OF VISITS
Every day for three to four days, then once a week for a month, then once or twice a month.
LAB & X-RAY
Urinalysis, CBC, EKG, chest x-ray, renal function tests (NPN, PSP, IVP, concentration tests, etc.).Fluoroscopy permissible. Serum electrolytes.
THERAPY
Sedatives, tranquilizers, digitalis, anti-coagulants, coronary vaso-dilators, anti-hypertensives, vaso-pressors, and anti-arrythymatics.
DURATION
Chronic.

EXAMPLE CASE No. 16

DIAGNOSIS
Benign neoplasms and tumors of an unspecified nature.
VISITS
Office.
FREQUENCY OF VISITS
Three plus or minus one.
LAB
Pathologic examination when indicated.
X-RAY
Rarely indicated, and then for treatment only.
THERAPY
Destruction or removal of lesion, sedatives, analgesics, and chemotherapy.
DURATION
Seven to ten days.

EXAMPLE CASE No. 17

DIAGNOSIS
Effects of foreign body entering orifice (ear, nose, throat, vagina, urethra, rectum).
VISITS
Office, three, plus or minus one.
FREQUENCY OF VISITS
First visit, then in day or two, then in a week.
LAB
None.
X-RAY
As indicated.
THERAPY
Analgesics, sedatives, removal by appropriate methods, and chemotherapy.
DURATION
Acute should be over in two to three days.

EXAMPLE CASE No. 18

DIAGNOSIS
Menopausal symptoms in absence of pre-existing psychoneurotic behavior or patterns.
VISITS
Office or home. No hospital. To diagnose, two visits plus or minus one, then once a month for two to three months, then once every three months.
LAB
CBC, urinalysis, pap smear, with estrogen evaluation.
X-RAY
None.
THERAPY
Sedatives, analgesics, tranquilizers, psychotherapy, and hormones (oral must be tried first).
DURATION
Indefinite (one to five years?).

EXAMPLE CASE No. 19

DIAGNOSIS
Arthritis and Spondylitis.
(A)
Osteo-arthritis.
VISITS
Office.
FREQUENCY
Once a week for three weeks, then once a month for six months.
X-RAY
Affected area.
LAB
Uric acid and routine blood work.
THERAPY
Analgesics, surgery, physiotherapy, steroids, by mouth, monarticular injections, local support, and cortisone.
DURATION
Indeterminate, often episodic.
(B)
Rheumatoid and infectious arthritis.
VISITS
Office or home.
FREQUENCY OF VISITS
Two to three times during first week, then weekly until medication is effective.
LAB
CBC, urine, sed. rate, LE preps, uric acid, RA, possibly EKG in severe case.
X-RAY
Affected joint.
THERAPY
Sedatives, tranquilizers, analgesics, aspiration, chemotherapy, steroids, heavy metals, and x-ray therapy.
DURATION
Episodic or chronic, acute phase may require intensive care.
(C)
Gouty arthritis.

VISITS
Two to three times during acute attacks; once every one to three months between attacks.
LAB
Uric acid, urinalysis and routine blood work.
X-RAY
IVP's.
THERAPY
Sedatives, tranquilizers, analgesics, colchicine, ACTH, steroids, and uricosuric drugs.
DURATION
Chronic and for life.

EXAMPLE CASE No. 20

DIAGNOSIS
Hay fever.
VISITS
Office. Two to four times for acute cases. Three times a week for four months desensitizing the chronic, then once every three to four weeks. Doctor must be present at desensitizations.
LAB
Acute, none. Nasal smear for eosinophils, sensitivity tests and elimination diets for chronic.
X-RAY
Possibly of sinus.
THERAPY
Sedatives, transquilizers, analgesics, anti-histamines, steroids, and desensitization.
DURATION
Seasonal or for life.

EXAMPLE CASE No. 21

DIAGNOSIS
Asthma, allergic and infectious.
VISITS
Office or home. Acute cases, two to four times per attack. Visits may be daily. Three times a week for four months for desensitizing the chronic, then once every three to four weeks. Doctor must be present at desensitizations.
LAB
Nasal smear for eosinophils, desensitization tests, elimination diets, pulmonary function tests, EKG, and definitely sputum studies.
X-RAY
Possibly sinus and chest x-ray.
THERAPY
Analgesics, sedatives, tranquilizers, inhalants, intermittant positive pressure, specific desensitization, steroids, bronchodilators, expectorants, anti-histamines, diet, and psychotherapy.

EXAMPLE CASE No. 22

DIAGNOSIS
Vascular lesions affecting central nervous systems.
COMMENT
Intensity of both therapy and investigation depends on the age of the patient and the suddenness and severity of the onset. The younger the patient, and/or the greater the acuteness and severity of the attack, the more energetic the treatment as outlined below. In the very elderly with long chronicity treatment may be minimal.
VISITS
Home and office.
FREQUENCY
At least once a day until acuity recedes, then at least once a month.
LAB
CBC and urine.
X-RAY
None.
THERAPY
Analgesics, sedatives, tranquilizers, vaso-dilators, anti-coagulants, anti-hypertensives, anti-convulsives, anti-de pressants, physiotherapy, and rehabilitation.

EXAMPLE CASE No. 23

DIAGNOSIS
Disorders of menstruation, bleeding episodes.
VISITS
Office or home.
FREQUENCY OF VISITS
Initial exam, up to daily if severe.
LAB
CBC, urine, crossmatch, PBI, endometrial biopsy, and pap smear.
X-RAY
None.
THERAPY
Hormones.
DURATION
If it is functional, two to three months, or may be for balance of reproductive life. If it is organic or recurrent, it probably should have surgery.

DIAGNOSIS
Amenorrhea.
LAB
Pregnancy tests, endocrine survey, and endometrial biopsy.
THERAPY
If repeated parenteral therapy, an explanation is required. Hormonal, usually oral.

EXAMPLE CASE No. 24

DIAGNOSIS
Synovitis.
VISITS
Home, office.
FREQUENCY
Daily for two to four visits, then, depending on response, up to once a week.
LAB
Tuberculin, CBC, and sed. rate.
X-RAY
Occasionally of affected joint or chest.
THERAPY
Analgesics, sedatives, tranquilizers, physiotherapy, steroids, mechanical support, and chemotherapy.
DURATION
Few days to months.

EXAMPLE CASE No. 25

DIAGNOSIS
Ulcer of duodenum.
VISITS
Office and home.
FREQUENCY OF VISITS
Initially, two times plus or minus one during first week, then in two weeks, then in six weeks (for x-ray), then once or twice a month.
LAB
CBC, urinalysis, stool for occult blood, gastric analysis or screening test of urine for acidity.
X-RAY
G. I. series, possibly gall bladder.
THERAPY
Analgesics, sedatives, tranquilizers, diet, anti-spasmodics, and antacids.
DURATION
Episodic or chronic.

EXAMPLE CASE No. 26

DIAGNOSIS
Rheumatism, muscular and unspecified.
VISITS
One visit to diagnose, then once a week for four weeks, then depends on response. Office or home.
LAB
On second or third visit, muscle biopsy, CBC, urine, sed. rate, and those for rheumatoid arthritis
X-RAY
None.
THERAPY
Local injection of anaesthetic, local injection of steroids, chemotherapy, and mechanical support, muscle relaxants.
DURATION
Episodic, three to four weeks.

DESCRIPTION OF REVIEW METHODS

Claims that do not pass the review criteria are referred to the Medical Review Department. They are first individually reviewed by a physician experienced in the type of case. He may request further information to clarify the need for the number of office visits, injections, physiotherapy, laboratory work, etc. He may need a copy of the history and physical, the operative report, or the pathology report. He may want to inquire as to the relationship of certain procedures to the given diagnosis, and he may need clarification on obscure diagnosis. Copies of these letters follow.

The Foundation Review Committee is unanimous in agreeing that claims review cannot be done without complete information as to the nature of the disease to relate to the diagnostic procedures and to the course of treatment. They also agree that "usual, customary and reasonable" payment cannot be made unless there is accurate documentation as to exactly what was done.

In the 11 month period just passed we have reviewed 77,586 physician claims under Medi-Cal. Of these 7,873 were submitted for individual review by physicians of which number 308 had to be reviewed by the Committee as a whole. The total dollars billed for physician services in the same period of time were $1,260,830 of which $77,077.14 were adjusted as not payable. Of this amount $16,834.15 were fee adjustments. The remainder were adjusted for overutilization.

This dollar volume was billed on 9,999 claims of which 2,899 claims were reviewed for fee determination; the remainder for overutilization. These figures bear out our continuing impression that quality control is, by far, more important than fee control. The enclosed letters illustrate communications to physicians and other providers regarding questionable overutilization or inadequate information. The letters, with the exception of the second letter, are, for the most part, self explanatory. The second letter illustrates the need for close cooperation between the facility providing the medical care and the Welfare Department as it relates to the patient's social problems. In this particular instance, after study by the Social Worker and consultation with the various physicians, the patient was placed on prior authorization and was limited to the services of the one physician of her choice.

SOME EXAMPLES OF CORRESPONDENCE BETWEEN THE FOUNDATION REVIEW COMMITTEE AND PHYSICIANS CONCERNING THE MEDI-CAL PILOT PROJECT

June 21, 1968

Chairman, Review Committee
Medi-Cal Claims Office
P. O. Box 0
Stockton, California

Dear Doctor

This is the second letter of this nature I have received from you and I, for one, am glad to see that this type of supervision is occurring and hope it will continue to do so.

I believe that this is another means of control which should be exercised more liberally.

Again thank you for your assistance in this matter.

Sincerely,

FOUNDATION FOR MEDICAL CARE
of San Joaquin County

1004 N. LINCOLN STREET P. O. BOX 230 STOCKTON, CALIFORNIA 95201 466-1481

December 28, 1966

TO WHOM IT MAY CONCERN:

At Dr. request, Dr. , Medical Consultant to the Welfare Department, was contacted regarding Mrs. Dr. suggested that her home situation be looked into to determine what sort of a person we are dealing with -- he feels this could be patient over-utilization. Dr. will follow up, and report back to me.

December 29, 1966

Dr. called, and reported the following on Mrs. "The main reason she is on ATD is because of schizophrenia. She left Dr. because of disagreements and difficulties. Dr. has been saddled with this woman, who calls for everything. She then chose Dr. The Social Worker says that she was informed that Mrs. is going to UC for 2 to 4 days for a diagnostic work-up. She probably has Rheumatic Heart Disease with Auricular Fibrillation; most probably Mitral Valve Insufficiency. Also has had Chronic Alcoholism. Her daughter is 2 months pregnant, and is quitting school. This, too, is upsetting her."

Respectfully submitted,

Executive Claims Officer

1/9/67 - Pay, but Watch! per Dr.

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

May 3, 1968

Re:

Dear Doctor

In order to make proper payment on the claim for the captioned patient, the Review Committee would appreciate receiving copies of the operative and pathological reports on surgery of March 1, 1968.

Your assistance in this matter will be greatly appreciated.

Sincerely yours,

M.D., Chairman
Review Committee

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

May 3, 1968

Re:

Dear Doctor

In processing the claim on the Review Committee will need to know the reason for a chest x-ray being done on November 7, 1967.

Your assistance in this matter will be greatly appreciated.

Sincerely yours,

M.D., Chairman
Review Committee

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

May 3, 1968

Re:

Dear Doctor

The claim on the captioned patient is being processed for payment. Your consultation of February 10, 1968 has been authorized on RVS procedure 9028 at 3 units.

If you feel this decision to be unfair, the Review Committee would appreciate receiving a copy of your consultation report.

The Committee would also appreciate information as to the complicating factors requiring 25 days hospitalization.

Your cooperation in this matter will be greatly appreciated.

Sincerely yours,

M.D., Chairman
Review Committee

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

May 3, 1968

Re:

Dear Doctor

In processing the claim on the captioned patient, the Review Committee would appreciate clarification on the diagnosis "Fluid Loss" as indicated on your claim for services rendered April 14, 1967 through December 18, 1967.

Your assistance in this matter will be greatly appreciated.

Sincerely yours,

M.D., Chairman
Review Committee

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

March 4, 1968

Re:

Dear Doctor

Your patient , at Convalescent Hospital, received toenail trimming on January 31, 1968 by Dr. .

If you authorized such care, please initial and return -- if not, would you so state, and return.

Sincerely yours,

M.D., Chairman
Review Committee

Yes; she has since that time become bed-ridden & order D.C'd - However, because of ingrowing of lat, edges she will receive 1 more treatment

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MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

May 3, 1968

Re:

Dear Doctor

In processing the claims on the captioned patient, the Review Committee will need to know the indications for Antuitrin S injections as it relates to the diagnoses. Also, the type of injections given on December 19, 29, 1967, January 16, 19, and 26, 1968 were not identified on your claim form.

As soon as the above information has been received the claims will be promptly processed.

Sincerely yours,

M.D., Chairman
Review Committee

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

February 20, 1968

Re:

Dear Doctor

A review of the prescriptions for the captioned patient shows that on January 8, 1968 he received 2 prescriptions for Probanthine, one for 120, and the other for 100 tablets, with the directions "1 tablet t.i.d. ac."

If this is in accordance with your instructions, would you kindly initial and return this letter.

Sincerely yours,

John I. Morozumi, M.D., Chairman
Review Committee

JIM:bc:ksp

SIR,

NO, I ONLY PRESCRIBED PROBANTHINE, 100 tablets.

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

March 25, 1968

Re:

Dear Doctors:

This letter is sent to you for your information regarding Mrs.

A review of recent claims passing through this office reveals that Mrs. has been receiving treatment from each of you, as noted above, and has been obtaining prescriptions for Empirin Compound #3 authorized by Doctor and by Doctor over the same period of time.

Perhaps you are aware that this individual has been seeing physicians other than yourself for the same problem (Arthritis). If not, this will suffice to inform you of the situation.

Sincerely yours,

John I. Morozumi, M.D., Chairman
Review Committee

JIM:lt:ksp

MEDI-CAL CLAIMS OFFICE

San Joaquin Foundation for Medical Care

445 WEST ACACIA STREET
TELEPHONE 948-9231
P. O. DRAWER "O", STOCKTON, CALIFORNIA 95201

June 3, 1968

Re:

Dear Doctor

A review of the prescriptions on the captioned patient indicates that, since January 6, 1968, she has received 1100 tablets of Thyroid, 3 gr., with the directions "1 daily."

If this apparent excess usage is in accordance with your knowledge and approval, would you please give us the diagnosis, and the reasons for this apparent overusage.

Sincerely yours,

John I. Morozumi, M.D., Chairman
Review Committee

JIM:bc:ksp

Dear Doctor Morozumi: 6/7/68

Apparently it would appear that someone has altered the prescription for as I have not ordered over 1,000 tablets of thyroid since 1/6/68, with directions of one daily. It is my assumption, someone has altered the prescription. I would like photostatic copies of these prescriptions. I usually order about 100 every 3 months.

I would certainly concur - this is an overusage, and this medication should not be used at this rate. Her diagnosis: Hypothyroidism.

Sincerely,

WGF/rm

TYPES OF REPORTS AVAILABLE

The following section illustrates the types of reports available. The first four reports deal with the control aspects of the system to insure the accuracy of the data being used by the Medical Review. All the remaining reports are actually used in the quality control of the Medical Care Program.

MEDICAL BATCH BALANCE

(See Table on Page 18)

After the documents have been completely processed by the Claims Review Department they are batched and sent to keypunch. These batches are in sequence by type of provider of service, i.e., physicians, hospital and prescription are in individual batches. A tally is run on the paid amount in each batch.

Note on the report that the batch sequence and document are identified as to the type. "RX" indicates prescription, "MD" indicates physician claim. We show the incoming total, and if the batch is in balance note there is no total printed out. However, if a document is rejected during the editing phase of this function, a reject code shown in this column gives the reason for that document to be rejected. The document is identified as to the sequence number, the patient I.D. #, physician license #, pharmacy license #, and the amount is shown. If the balance of the batch is in order, a new adjusted amount is set up in the control, and this batch will go through the system minus the rejects, but it is not held up because one or two documents have an error code and are rejected. It enables us to completely process the balance of the correct documents without worrying about the ones which are sent back to be manually re-researched, corrected, and resubmitted in a new batch.

PROCEDURE REJECT REGISTER

(See Table on Page 19)

After all the items have been batched and edited they are then sorted into procedure number sequence, procedure number being either ICDA (International Classification of Disease Adapted) code for the diagnosis, or the RVS (Relative Value Studies) code for procedures done by physicians, or it could be the SMA (Schedule of Maximum Allowance) code. All of these codes are used in the Medi-Cal system.

Each code is matched against the master file, and additional information is picked up, such as, description, unit value of an RVS procedure, or dollar amount in the SMA coding. Any item that does not find its match is rejected and returned for further research and manual checking. Once the document has been completed and corrected, it is then resubmitted to the computer. All necessary information identifying that unique document is shown on each reject register. At the same time, at the end of this report, there are the necessary control totals taken that will enable us to keep proper control throughout the system.

PROVIDER REJECT REGISTER

(See Table on Page 20)

After the items have been matched against the procedures they are sorted into the provider license number sequence, and passed against the provider master file. It a non-match is found, that item is rejected and shown on this report. It is then manually researched, corrected, and sent back through the computer. All the necessary information enabling us to easily identify that particular document is shown so that it can be manually pulled, corrected, and resubmitted.

RECIPIENT REJECT REGISTER

(See Table on Page 21)

The next step in processing is sorting the incoming file into recipient sequence. They are sorted by patient identification number within aid category, within county, and passed against the master-patient file. Any non-matches found are rejected and listed. These lists are returned for correction and re-submission.

At the end of this report, and all previous reports shown, there are control figures so that we know the exact dollar amounts that are entering the system. The number of records we have received on this current cycle, and the number of records we have previously put on our year-to-date tape, are summated to produce accurate records of all items received. These controls insure the accuracy of the various reports produced that are utilized in the quality review procedures.

PATIENT PROFILE

(See Table on Page 22)

The patient's profile is, without question, THE single most important document in reviewing for the quality of medical care.

The patient profile enclosed is one of a family of three whose profiles are similar to the one enclosed. You will note that the profile contains a great deal of information about the patient, including a list of diagnoses services rendered, materials and drugs prescribed; all related to the dates of services so that medical necessity can be verified. You will notice, also, that in every instance the provider can be identified, and in the case of prescribed items not only the provider of the item can be identified, but also the person prescribing the item is identified, and can be related back to other services rendered by the prescriber. You will also notice that all prescriptions are listed with the amount prescribed, and a description of the physician's order as to how it is to be taken. For instance, 12 pentobarbitals with the physician's order of one at bedtime (1 HS). Overutilization would occur if the refill came in considerably less than 12 days. Without these two pieces of information, determination of drug overutilization is impossible.

PHYSICIAN'S (PROVIDER) PROFILE

(See Table on Page 28)

The patient profile allows us to do quality review prior to payment of any questionable claims. However, the profile of each provider must also be maintained. It is possible in a large volume practice for each individual patient profile and each individual claim form to appear proper and yet a survey of the provider's practices may reveal gross overutilization.

The profile of two physicians who recently came to our community is illustrated. You will notice they have done 101 tonsillectomies. In the same period of time the total community did 357.

You will also notice that their ratio of home and office visits to injections is one injection to every 1½ office visit. (Much higher than the community norm). You will notice on the summary page that they were brought to Committee in July, 1968, and considerable improvement has occurred since that time.

PHYSICIAN'S PROFILE PLUS HIS DRUG PROFILE

(See Table on Page 31)

Viewing a physican's profile in a vacuum does not give the complete story. The following physician's profile demonstrates a physician who was brought to the Review Committee in 1967 because of a large "shot practice." His present physician profile reveals no problems. You will notice that he has had no items brought to the Committee, and that his ratio is one injection to every 16 visits. However, if you will turn to his prescriber profile, which is next, this reveals on Pages 493 through 498 the fact that, in the same period of time, he prescribed $24,026.50 worth of drugs, and that for 345 patients he prescribed 23,914 tablets of Codeine and Aspirin, or 69 per person, and, that for 77 persons, he prescribed 11,384 tablets of Mellaril. We are now breaking down this prescription practice by drug store, and to identity, by individual, the 345 persons receiving Codeine and Aspirin. At this point we do not have these reports.

PROFILES OF OTHER VENDORS

(See Table on Page 43)

1. Overall Drug Store Summary
2. Hospital
3. Podiatrist
4. Chiropractor
5. Dispensing Ophthalmologists or Opticians
6. Lay Lab
7. Hearing Aids

FINANCIAL RECAPITULATION OF BILLINGS FOR PHYSICIAN'S SERVICES AND FOR PHARMACY

(See Table on Page 50)

These two reports recapitulate the payments made for the activity of approximately 10 months. The computer is programmed to identify the total items that are subjected to review whether it be for fee, overutilization, or complete rejection. It also identifies those items that have been sent to Committee and the amounts involved. This review information is also available on the patient profile and on each provider profile.

BATCH CONTROL					REJECTED ITEMS IN BATCH					RESULTS OF ERROR-CHECKING & BALANCING	
BATCH	SEQ	DOC DAY	CLAIM TYPE	INCOMING TOTAL	PATIENT I.D.	PRES #	PHARMACY	AMOUNT	REJ. CODE	ADJUSTED AMOUNT	COMPUTER ANALYSIS
956	800	122	Rx	44.25						44.25	▪ IN BALANCE
957	500	122	Rx	618.84						618.84	▪ IN BALANCE
956	100	125	Rx	450.60	Corrected					447.85	OUT OF BALANCE BY Document 2.75
956	200	125	Rx	445.72						445.72	▪ IN BALANCE
956	300	125	Rx	335.48						335.48	▪ IN BALANCE
956	500	125	Rx	461.96						461.96	▪ IN BALANCE
956	400	125	Rx	413.73						413.73	▪ IN BALANCE
956	600	125	Rx	446.21	Corrected						
	652				39-30-000003885- -	178399	A9628	2.75	17 ✓	444.46	OUT OF BALANCE BY Bush 1.00-
956	700	125	Rx	424.66						424.66	▪ IN BALANCE
956	800	125	Rx	416.72						416.72	▪ IN BALANCE
956	900	125	Rx	406.20						406.20	▪ IN BALANCE
950	300	118	MD	944.00						944.00	▪ IN BALANCE
951	835	118	MD	651.70						651.70	▪ IN BALANCE
951	953	118	MD	17.50	Corrected						
	968				39-30-000013062- -				17		
	968				39-30-000013062- -				17 ✓		
	968				39-30-000013062- -				17	17.50	▪ IN BALANCE
952	1	128	MD	638.25						638.25	▪ IN BALANCE

CODE NO	PATIENT IDENTIFICATION NO.	JULIAN DATE	BATCH NO.	SEQ NO.	CLAIM TYPE	PRESCRIBLR	PROVIDER	PRESCRIPTION NUMBER	AMOUNT PAID
1 02593	39 30 000019002 1 50	128	951	649	MD 20		0 C19987		.
1 03537	55 63 000000020 0 00	118	950	674	MD 20		Z 32926		.
1 04467	39 37 000016354 1 50	118	950	684	MD 20		0 A11256		.
1 04833	39 30 000005489 1 01	122	950	494	MD 20		0 A16204		.
1 04929	39 30 000007466 1 02	128	951	950	MD 20		0 20A1909		.
1 05319	05 60 000000176 0 00	128	951	305	MD 20		0 A10483		.
1 08467	39 10 000020416 0 00	129	950	940	MD 30		0 8781		.
2 00015	39 30 000009292 1 01	125	950	607	MD 20		0 A18124		5.00
2 05440	39 10 000022886 0 00	129	950	315	MD 20		0 A18123		25.00
2 05440	39 10 000009069 0 00	129	950	322	MD 20		0 A18123		25.00
2 08645	39 60 000008851 0 00	128	951	623	MD 20		0 C19987		6.00
2 08645	39 30 000020172 1 50	128	951	528	MD 20		0 C19987		6.00
2 08926	39 30 000017784 1 50	128	950	530	MD 20		Z 40315		1.75
3 0224H	39 30 000013375 1 01	104	956	395	RX 26	0 20A1859	0 D12076	054184	3.00
3 0617A	39 37 000003777 1 50	112	955	132	RX 26	0 A21506	0 D6988	127996	3.80
3 0769B	39 13 000014305 0 00	112	955	305	RX 26	0 G11269	0 A12156	053010	7.10
3 0769B	39 13 000014305 0 00	112	955	311	RX 26	0 G11269	0 A12156	052434	7.10
3 0769B	39 13 000014305 0 00	112	955	308	RX 26	0 G11269	0 A12156	051839	7.10
3 1008A	39 60 000008415 0 00	121	955	570	RX 26	0 A12260	0 A12877	613535	2.75
3 1064A	03 30 000010547 0 50	111	955	886	RX 26	0 20A1968	0 A433	226719	3.25
3 1064A	39 10 000016067 0 00	115	955	111	RX 26	0 20A2187	0 D14366	065368	3.90
3 1120A	39 10 000020370 0 00	118	955	870	RX 26	0 A10652	0 A11077	528577	2.95
3 1608E	39 60 000009010 0 00	122	957	615	RX 26	0 A08167	0 D6988	126989	4.30
3 1608H	39 60 000008001 0 00	118	956	045	RX 26	0 A12260	0 A11077	528995	2.75
3 1700A	55 10 000002400 0 00	121	955	007	RX 26	0 A12874	0 A13205	063902	3.70
3 1800S	39 10 000021761 0 00	121	955	418	RX 26	0 A20344	0 A11077	528240	3.30
3 2006E	03 10 000010471 0 00	122	955	561	RX 26	0 20A1269	0 A1273	152192	1.95
3 2063E	39 10 000021761 0 00	113	955	211	RX 26	0 A12531	0 A11077	528275	2.95
3 2063F	39 60 000005703 0 00	113	955	438	RX 26	0 R98700	0 A4464	139543	9.95
3 2303C	39 60 000000657 0 00	119	955	609	RX 26	0 20A1371	0 D12076	054886	3.85
3 2504A	39 10 000024265 0 00	121	955	368	RX 26	0 A21506	0 D4301	142372	2.75
3 2505H	39 30 000006274 1 02	105	955	105	RX 26	0 C19987	0 A10244	147550	2.85
3 2507H	39 30 000008549 1 02	105	955	203	RX 26	0 C20709	0 A10244	147448	3.20
3 2507H	39 30 000018532 1 50	105	955	915	RX 26	0 C19987	0 A10244	147097	3.20
3 2509H	39 35 000017270 1 01	105	955	733	RX 26	0 C20709	0 A10244	147107	3.20
3 2510H	55 60 000000411 0 00	121	955	164	RX 26	0 C8492	0 A1784	346701	2.85
3 2516A	39 30 000006611 1 04	118	955	652	RX 26	0 A16204	0 D11078	183466	2.80
3 2516A	39 30 000006734 1 01	121	955	410	RX 26	0 A16204	0 D11078	182545	2.80
3 2517F	39 10 000023267 0 00	118	955	349	RX 26	0 C30278	0 A10714	702426	2.95
3 2517F	55 10 000002895 0 00	104	955	430	RX 26	0 R98700	0 D14075	106962	3.35
3 2630A	39 30 000014469 1 50	118	955	832	RX 26	0 C20778	0 A12328	314528	2.25
3 2641E	39 13 000019259 0 00	112	955	139	RX 26	0 A11901	0 A12156	051955	1.60
3 2685C	39 13 000019028 0 00	112	955	324	RX 26	0 C8724	0 A12156	052864	3.65
3 2685C	39 13 000019028 0 00	112	955	327	RX 26	0 C8724	0 A12156	052138	3.65
3 2685C	39 13 000019028 0 00	112	955	326	RX 26	0 C8724	0 A12156	051799	3.65
3 2902C	39 30 000017195 1 04	112	955	034	RX 26	0 A16202	0 D6988	127607	4.10
3 2935A	39 10 000017293 0 00	112	955	339	RX 26	0 20A1909	0 A12870	377648	6.30
3 2940R	39 60 000003506 0 00	112	955	704	RX 26	0 A13420	0 A12156	052164	3.80
3 3050B	39 60 000002666 0 00	112	956	164	RX 26	0 A20344	0 A12813	214278	4.30
3 3301E	39 10 000018417 0 00	118	955	861	RX 26	0 C23674	0 A11077	529391	2.60

MED-CAL PROVIDER REJECT REGISTER MD-130 DATE 05/16/69

BATCH NO.	SEQ NO.	PATIENT ID	JULIAN DATE	CLAIM TYPE	PRESCRIBER LIC NO.	PROVIDER LIC NO.	CODE TYPE	ICDA RVS SMA DRUG CODE	AMOUNT BILLED	CBS
950	537	39-60-000008550-0-00	122	MD20		020705	2	08622	3.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	09900	4.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	09004	6.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	08641	6.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	1	07873		000207050
950	537	39-60-000008550-0-00	122	MD20		020705	1	02920		000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	09004	9.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	1	07837		000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	09900	4.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	08661	6.00	000207050
950	537	39-60-000008550-0-00	122	MD20		020705	2	09101	18.00	000207050
950	635	39-30-000008208-1-04	128	MD20		020705	2	A0375	4.00	000207050
950	635	39-30-000008208-1-04	128	MD20		020705	2	09004	9.00	000207050
950	635	39-30-000008208-1-04	128	MD20		020705	1	08422		000207050
950	635	39-30-000008208-1-04	128	MD20		020705	1	00510		000207050
950	635	39-30-000008208-1-04	128	MD20		020705	2	09026	18.00	000207050
950	635	39-30-000008208-1-04	128	MD20		020705	1	04720		000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	09004	6.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	09004	6.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	09005	9.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	08628	7.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	08722	6.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	1	06909		000207050
950	636	39-30-000008208-1-50	128	MD20		020705	2	09005	9.00	000207050
950	636	39-30-000008208-1-50	128	MD20		020705	1	05430		000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	09004	6.00	000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	09004	6.00	000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	09004	6.00	000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	A0540	4.00	000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	09004	6.00	000207050
950	637	39-30-000009618-1-01	128	MD20		020705	1	04910		000207050
950	637	39-30-000009618-1-01	128	MD20		020705	2	A0375	4.00	000207050
950	638	39-30-000008904-1-05	128	MD20		020705	2	A0235	5.00	000207050
950	638	39-30-000008904-1-05	128	MD20		020705	2	09004	6.00	000207050
950	638	39-30-000008904-1-05	128	MD20		020705	2	09024	18.00	000207050
950	638	39-30-000008904-1-05	128	MD20		020705	2	09022	36.00	000207050
950	638	39-30-000008904-1-05	128	MD20		020705	1	03900		000207050
950	638	39-30-000008904-1-05	128	MD20		020705	1	08520		000207050
950	639	39-30-000019982-1-01	128	MD20		020705	2	09005	9.00	000207050
950	639	39-30-000019982-1-01	128	MD20		020705	1	01319		000207050
950	573	39-32-000004423-1-04	118	MD20		0A1986	2	04802	75.00	000A19860
950	573	39-32-000004423-1-04	118	MD20		0A1986	1	06600		000A19860
952	390	39-30-000020360-1-60	128	MD20		0A1986	1	05604		000A19860
952	390	39-30-000020360-1-60	128	MD20		0A1986	2	03117		000A19860
952	390	39-30-000020360-1-60	128	MD20		0A1986	2	03117	84.00	000A19860
950	658	39-37-000018144-1-50	118	MD20		0A05094	2	09005	9.00	00AC50940
950	658	39-37-000018144-1-50	118	MD20		0A05094	1	03100		00AC50940
950	658	39-37-000018144-1-50	118	MD20		0A05094	1	03240		00AC50940
950	533	39-10-000023556-0-00	129	MD20		0A05424	2	A0010	3.00	00AC54240
950	533	39-10-000023556-0-00	129	MD20		0A05424	1	00000		00AC54240

BATCH NO.	SEQ NO.	PATIENT ID	JULIAN DATE	CLAIM TYPE	PRESCRIBER LIC. NO.	PROVIDER LIC. NO.	CODE TYPE	ICDA RVS OR DRUG CODE	AMOUNT PAID
955	670	03-10- 10108-0-00	122	Rx26	020A1269	0A1273	3	2157F	2.10
955	904	03-10- 10352-0-00	111	Rx26	020A1269	0A433	3	6800A	3.50
956	681	03-10- 10352-0-00	104	Rx26	020A1269	0A433	3	2155H	4.50
956	682	03-10- 10352-0-00	104	Rx26	020A1269	0A433	3	2611B	7.30
956	680	03-10- 10352-0-00	104	Rx26	020A1269	0A433	3	3324B	6.20
955	427	03-10- 10434-0-00	113	Rx26	0C24022	0A6949	3	3309B	6.05
955	426	03-10- 10434-0-00	113	Rx26	0C24022	0A6949	3	3514A	4.80
955	252	03-10- 10477-0-00	121	Rx26	0A11781	0D9034	3	2302C	4.35
955	253	03-10- 10477-0-00	121	Rx26	0A11781	0D9034	3	2611B	5.90
955	025	03-10- 10477-0-00	111	Rx26	0A11781	0D9034	3	2302B	4.00
955	059	03-10- 10477-0-00	107	Rx26	0A11060	0D9034	3	2302B	4.00
950	770	03-10- 10580-0-00	129	MD30		09738	4	00201	4.00
950	770	03-10- 10580-0-00	129	MD30		09738	4	00201	4.00
950	770	03-10- 10580-0-00	129	MD30		09738	4	00201	4.00
950	770	03-10- 10580-0-00	129	MD30		09738	4	00201	4.00
950	770	03-10- 10580-0-00	129	MD30		09738	1	08476	
950	770	03-10- 10580-0-00	129	MD30		09738	4	00201	4.00
955	176	03-10- 10603-0-00	118	Rx26	0C24022	0A433	3	0163C	4.10
955	175	03-10- 10603-0-00	118	Rx26	0C24022	0A433	3	2157F	2.90
955	874	03-10- 102972-0-00	111	Rx26	0A15512	0A433	3	5262D	2.25
955	390	03-20- 2019-0-00	113	Rx26	0A15512	0A6949	3	3000D	2.65
955	389	03-20- 2019-0-00	113	Rx26	0A15512	0A6949	3	3513B	4.85
955	391	03-20- 2019-0-00	113	Rx26	0A15512	0A6949	3	6351A	6.45
955	713	03-35- 595-0-50	121	Rx26	0C24022	0A6949	3	2954A	4.50
951	174	03-37- 10445-0-03	129	MD20		0C24022	1	04730	
951	174	03-37- 10445-0-03	129	MD20		0C24022	2	09026	12.00
955	878	03-37- 10445-0-04	111	Rx26	020A1269	0A433	3	0244K	3.15
955	877	03-37- 10445-0-04	111	Rx26	020A1269	0A433	3	2508A	3.30
955	875	03-37- 10445-0-50	111	Rx26	020A1269	0A433	3	0244H	3.05
955	876	03-37- 10445-0-50	111	Rx26	020A1269	0A433	3	2514A	3.80
957	684	03-30- 10479-0-50	122	Rx26	020A1968	0A433	3	1736B	4.25
951	488	03-30- 10504-0-50	128	MD20		0A13766	1	08450	
951	488	03-30- 10504-0-50	128	MD20		0A13766	2	09004	5.00
951	484	03-30- 10504-0-50	128	MD20		0A13766	2	09004	
951	484	03-30- 10504-0-50	128	MD20		0A13766	1	08450	
951	484	03-30- 10504-0-50	128	MD20		0A13766	2	09026	18.00
955	432	03-34- 10520-0-50	113	Rx26	0A15512	0A6949	3	0244H	2.30
955	433	03-34- 10520-0-50	113	Rx26	0A15512	0A6949	3	6215B	2.25
950	563	03-37- 10568-0-60	118	MD20		Y20394	2	07101	18.00
951	154	03-34- 10620-0-01	129	MD20		0A15512	1	04730	
951	154	03-34- 10620-0-01	129	MD20		0A15512	2	09004	5.00
951	155	03-34- 10620-0-50	129	MD20		0A15512	1	07910	
951	155	03-34- 10620-0-50	129	MD20		0A15512	2	09004	5.00
952	155	03-35- 10628-0-60	128	MD20		0C9638	1	04830	
952	155	03-35- 10628-0-60	128	MD20		0C9638	2	09004	6.00
955	884	03-35- 10629-0-02	111	Rx26	0A15512	0A433	3	8940J	2.60
955	883	03-35- 10629-0-02	111	Rx26	0A15512	0A433	3	9101A	3.40
951	734	03-35- 10629-0-50	128	MD20		0A15512	1	05602	
951	734	03-35- 10629-0-50	128	MD20		0A15512	1	06050	
951	734	03-35- 10629-0-50	128	MD20		0A15512	2	08936	3.00
951	734	03-35- 10629-0-50	128	MD20		0A15512	2	09004	6.00
955	174	03-35- 10629-0-50	118	Rx26	0A15512	0A433	3	2302C	3.30
955	714	03-34- 10664-0-50	121	Rx26	0A13766	0A6949	3	0204D	3.05
955	179	03-60- 1304-0-00	118	Rx26	0A15512	0A433	3	2601K	4.40

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Date of Service	Vendor No. & Type	Procedure or diagnosis Code	Name	Frequency	Where Done	Billed	Paid	Review	Claim No.
03-04-69	0A13028 20	MD-1-07440	MYASTHENIA GRAVIS						1140874
03-04-69	0A13028 20	MD-1-07841	NAUSEA-VOMITING						1140874
03-04-69	0A13028 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		1140874
03-04-69	0A13028 20	MO-2-A0270	COMPAZINE	1		5.00	5.00		1140874
02-21-69	0A13028 20	MO-1-07440	MYASTHENIA GRAVIS						1041572
02-21-69	0A13028 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		1041572
01-02-69	0A13028 20	MO-1-07440	MYASTHENIA GRAVIS						0842457
01-02-69	0A13028 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0842457
11-13-68	Y35057 20	MO-1-05300	DENTAL CARIES						1280982
11-13-68	Y35057 20	MD-2-02815	I&D ABSCESS	8	IPH	56.00	48.00	A	1280982
11-09-68	Y90217 20	MD-1-07910	HEADACHE						0550317
11-09-68	Y90217 20	MD-2-09000	INITIAL OFFICE VISIT	1		10.00	10.00		0550317
11-02-68	0A13028 20	MD-1-07440	MYASTHENIA GRAVIS						0550680
11-02-68	0A13028 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0550680
10-25-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410636
10-21-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		0410636
10-21-68	020A1016 20	MO-2-09900	INJECTIONS	1		1.00		3	0410636
10-18-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410636
10-18-68	020A1016 20	MD-2-09900	INJECTIONS	1		1.00		3	0410636
10-14-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		0410636
10-12-68	0A13028 20	MO-1-04720	ACUTE PHARYNGITIS						0410115
10-12-68	0A13028 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410115
10-11-68	020A1016 20	MO-2-00130	INC-REM FB	1		12.00	12.00		0410636
10-04-68	020A1016 20	MO-1-05000	BRONCHITIS ACUTE						0410636
10-04-68	020A1016 20	MO-1-05190	PLEURISY						0410636
10-04-68	020A1016 20	MO-1-06350	MENOPAUSAL SYMPTOMS						0410636
10-04-68	020A1016 20	MO-1-07910	HEADACHE						0410536
10-04-68	020A1016 20	MD-1-08260	FX TOES FOOT CL						0410636
10-04-68	020A1016 20	MO-1-09220	CONT. TRUNK						0410636
10-04-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410636
09-21-68	Z20686 20	MO-1-05710	GASTROENTERITIS						3581193
09-21-68	Z20686 20	MO-2-09000	INITIAL OFFICE VISIT	1	OPH	10.00	10.00		3581193
09-21-68	Z20686 20	MO-2-09900	INJECTIONS	1	OPH	9.00	9.00		3581193
09-21-68	Z20686 20	MD-2-A0300	DEMEROL	1	OPH	9.00	9.00		3581193
09-13-68	0A13028 20	MO-1-07440	MYASTHENIA GRAVIS						0410111
09-13-68	0A13028 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00	R	0410111
09-12-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410635
09-10-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		0410635
09-10-68	020A1016 20	MD-2-09900	INJECTIONS	1		1.00		3	0410635
09-09-68	Y32637 20	MO-2-08936	URINALYSIS ROUTINE	1		2.50	2.50		0411506
09-09-68	Y32637 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		0411506
09-04-68	020A1016 20	MO-1-03540	MIGRAINE						0410635
09-04-68	020A1016 20	MD-1-03660	OTHER NEURALGIA&NEURITIS						0410635
09-04-68	020A1016 20	MO-1-05789	RECTAL DISEASE						0410635
09-04-68	020A1016 20	MD-1-06050	CYSTITIS						0410635
09-04-68	020A1016 20	MD-1-06070	URETHRITIS						0410635
09-04-68	020A1016 20	MD-1-06350	MENOPAUSAL SYMPTOMS						0410635
09-04-68	020A1016 20	MO-1-08260	FX TOES FOOT CL						0410635
09-04-68	020A1016 20	MD-2-09005	FOLLOW-UP OFF. VISIT	1		9.00	7.50	2	0410635
09-04-68	020A1016 20	MD-2-A0580	TERRAMYCIN	1		1.00		3	0410635
09-04-68	Y32637 20	MO-1-06070	URETHRITIS						0411506
09-04-68	Y32637 20	MD-2-09073	NIGHT CALL	1		12.00	12.00	R	0411506
08-30-68	0A13028 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00	R	3581112
08-30-68	0A13028 20	MO-2-A0270	COMPAZINE	1		5.00	5.00	R	3581112
08-24-68	0A13028 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00	R	3581112
08-24-68	0A13028 20	MD-2-A0515	PENICILLIN	1		5.00	5.00	R	3581112
08-16-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		0410632
08-09-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		0410632
08-02-68	020A1016 20	MD-1-06350	MENOPAUSAL SYMPTOMS						0410632
08-02-68	020A1016 20	MO-1-07910	HEADACHE						0410632

Date of Service	Vendor No. & Type	Procedure or Diagnosis Code	Name	Frequency	Where Done	Billed	Paid	Review	Claim No.
08-02-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00	R	0410632
08-01-68	0A13028 20	MO-1-03700	CONJUNCTIVITIS						3581112
08-01-68	0A13028 20	MD-1-04730	ACUTE TONSILLITIS						3581112
08-01-68	0A13028 20	MD-1-06940	LYMPHADENITIS ACUTE						3581112
08-01-68	0A13028 20	MO-1-07842	NAUSEA-VOMITING						3581112
08-01-68	0A13028 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00	R	3581112
07-26-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		2600375
07-26-68	020A1016 20	MO-2-09900	INJECTIONS	1		1.00	1.00		2600375
07-19-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		2600375
07-12-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		2600375
07-08-68	0A13028 20	MO-1-05000	BRONCHITIS ACUTE						2600299
07-08-68	0A13028 20	MO-1-05270	OTER OIS LUNG&PLEURALCAV						2600299
07-08-68	0A13028 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		2600299
07-08-68	0A13028 20	MD-2-A0235	BICILLIN	1		5.00	5.00		2600299
07-05-68	020A1016 20	MD-2-00251	REPAIR WOUND	1	OPH	14.00	12.00	2	2600375
07-01-68	020A1016 20	MD-1-05710	GASTROENTERITIS						2600375
07-01-68	020A1016 20	MD-1-06350	MENOPAUSAL SYMPTOMS						2600375
07-01-68	020A1016 20	MD-1-07411	BURSITIS SHOULDER						2600375
07-01-68	020A1016 20	MO-1-07910	HEADACHE						2600375
07-01-68	020A1016 20	MD-1-08799	OTHER UNSPEC. WOUNDS						2600375
07-01-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600375
06-28-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600675
06-17-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600675
06-14-68	020A1016 20	MD-2-01913	NEEDLE PNCT. BURSA	1		12.00	12.00		2600675
06-10-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600675
06-07-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600675
06-06-68	0A13028 20	MD-1-00006	TUBERCULOSIS,RESP UNSPEC.						2600857
06-06-68	0A13028 20	MO-2-09014	HOME VISIT	1	H	12.00	12.00		2600857
06-04-68	020A1016 20	MD-1-04719	ACUTE SINUSITIS						2600675
06-04-68	020A1016 20	MD-1-06350	MENOPAUSAL SYMPTOMS						2600675
06-04-68	020A1016 20	MD-1-07411	BURSITIS SHOULDER						2600675
06-04-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600675
05-28-68	0A13028 20	MD-2-00108	I & D ABSCESS	1		12.00	12.00		1767022
05-27-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600674
05-24-68	020A1016 20	MO-2-09941	THERAPY	1		7.20	7.20		2600674
05-20-68	020A1016 20	MO-2-09941	THERAPY	1		7.20	7.20		2600674
05-17-68	020A1016 20	MO-2-A0580	TERRAMYCIN	1		1.00	1.00		2600674
05-13-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		2600674
05-10-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		2600674
05-10-68	020A1016 20	MD-2-A0580	TERRAMYCIN	1		1.00	1.00		2600674
05-06-68	020A1016 20	MO-2-09949	OV W/THERAPY	1		7.20	7.20		2600674
05-04-68	0A13028 20	MD-2-07103	X-RAY CHEST	1		12.00	11.00		1767022
05-04-68	0A13028 20	MD-2-09101	EKG	1		18.00	18.00		1767022
05-03-68	020A1016 20	MO-1-02400	HAY FEVER-POLLENS						2600674
05-03-68	020A1016 20	MD-1-04719	ACUTE SINUSITIS						2600674
05-03-68	020A1016 20	MD-1-08460	SPRAIN SACROILIAC						2600674
05-03-68	020A1016 20	MD-2-09949	OV W/THERAPY	1		7.20	7.20		2600674
05-01-68	0A13028 20	MO-1-05000	BRONCHITIS ACUTE						1767022
05-01-68	0A13028 20	MD-1-06909	CARBUNCLE UNSPEC						1767022
05-01-68	0A13028 20	MD-1-07837	CHEST PAIN						1767022
05-01-68	0A13028 20	MD-2-09000	INITIAL OFFICE VISIT	1		10.00	10.00		1767022
04-26-68	020A1016 20	MO-2-09941	THERAPY	1		7.20	7.20		1766033
04-22-68	020A1016 20	MO-2-09900	INJECTIONS	1		1.00	1.00		1766033
04-18-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		6.00	6.00		1766033
04-15-68	020A1016 20	MD-2-09004	OFFICE VISIT	1		6.00	6.00		1766033
04-15-68	020A1016 20	MD-2-09900	INJECTIONS	1		1.00	1.00		1766033
04-12-68	020A1016 20	MO-2-09004	OFFICE VISIT	1		7.20	6.00	2	1766033
04-05-68	020A1016 20	MO-1-04719	ACUTE SINUSITIS						1766033
04-05-68	020A1016 20	MO-1-06350	MENOPAUSAL SYMPTOMS						1766033
04-05-68	020A1016 20	MO-1-07262	TORTICOLLIS						1766033

Date of Service	Vendor No. & Type	Procedure or Diagnosis Code	Name		M.D.'s Pres. Order (How to take)	Frequency	Billed	Paid	Review	Claim No.
04-05-68	020A1016 20	MD-2-09004	OFFICE VISIT			1 Prescriber's	6.00	6.00		1766033
04-05-68	020A1016 20	MD-2-09900	INJECTIONS			1 License	1.00	1.00		1766033
05-05-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		1297875
05-05-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		1297876
04-28-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		1225199
04-28-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		1225200
04-24-69	0A11512 26	RX-3-9801A	DIPHENOXYLATE HCL/ATSO4	2.5MG	3	12 020A1016	3.00	3.00		1155243
04-23-69	0A11512 26	RX-3-2612C	AMITRIPTYLINE TABLET	25MG	17	50 020A1016	5.90	5.90		1155244
04-21-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		1135550
04-21-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		1135551
04-14-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		1085680
04-14-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		1085679
04-12-69	0A11090 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	UTD	24 0A1302B	2.75	2.75		1085447
04-12-69	0A11090 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	UTD	30 0A1302B	3.55	3.55		1085446
04-11-69	0A11512 26	RX-3-9124J	H.C./100DCHLORHYDROXYQUIN	1%-20GM	UTD	20 0C24276	5.45	5.45		1055125
04-07-69	0A11512 26	RX-3-2601J	PROCHLORPERAZINE SUSTAIN	10MG	24	24 020A1016	5.20	5.20		0985294
04-07-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0985290
04-07-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		0985291
03-31-69	0A11512 26	RX-3-0244H	TETRACYCLINE TAB-CAP	250MG	4	15 020A1016	2.95	2.95		0935008
03-31-69	0A11512 26	RX-3-0244H	TETRACYCLINE TAB-CAP	250MG	4	15 020A1016	2.95	2.95		0935008
03-31-69	0A11512 26	RX-3-2612C	AMITRIPTYLINE TABLET	25MG	8	24 020A1016	4.05	4.05		0935007
03-31-69	0A11512 26	RX-3-2612C	AMITRIPTYLINE TABLET	25MG	8	24 020A1016	4.05	4.05		0935007
03-31-69	0A11512 26	RX-3-8005C	CHLORPHENIRAMINE MAL TAB	4MG	17	50 020A1016	3.50	3.50		0935009
03-31-69	0A11512 26	RX-3-8005C	CHLORPHENIRAMINE MAL TAB	4MG	17	50 020A1016	3.50	3.50		0935009
03-31-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0935010
03-31-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0935010
03-31-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		0935011
03-31-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		0935011
03-29-69	0A11512 26	RX-3-2627A	ACETOPHENAZINE MAL. TAB.	20MG	6	12 020A1016	2.85	2.85		0905286
03-29-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0905303
03-29-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		0905302
03-17-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0795275
03-17-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10	20 0A12340	2.75	2.75		0795276
03-12-69	0A11512 26	RX-3-0244H	TETRACYCLINE TAB-CAP	250MG	3	15 020A1016	2.95	2.95		0765713
03-11-69	0A11512 26	RX-3-1800A	BELLADONNA ALKALOIDS&BARB	TABLETS	7	30 020A1016	2.70	2.70		0725712
03-11-69	0A11512 26	RX-3-2601S	PROCHLORPERAZINE SUPPOS	25MG	1	3 020A1016	3.05	3.05		0725711
03-10-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0725699
03-10-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	10	20 0A12340	3.15	3.15		0725698
03-03-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	10	10 0A12340	2.50	2.50		0647014
03-03-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	10	20 0A12340	3.15	3.15		0647013
03-02-69	0A11512 26	RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	2	15 0R98700	2.70	2.70		0647016
02-24-69	0A11512 26	RX-3-2612C	AMITRIPTYLINE TABLET	25MG	13D	50 020A1016	5.90	5.90		0575700
02-24-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		0575702
02-24-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		0575701
02-17-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		0491028
02-17-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		0491029
02-11-69	0A11512 26	RX-3-0265K	ERYTHROMYCIN TAB-CAP	250MG	16H	16 020A1016	5.80	5.80		0450995
02-11-69	0A11512 26	RX-3-1034A	PSEUDOEPHEDRINE TAB	60MG	1T3D	24 020A1016	3.10	3.10		0451344
02-10-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		0440888
02-10-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T2D	20 0A12340	3.15	3.15		0440887
02-03-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		0381099
02-03-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T2D	20 0A12340	3.15	3.15		0381100
01-27-69	0A11512 26	RX-3-0244H	TETRACYCLINE TAB-CAP	250MG	1L3D	12 020A1016	2.80	2.80		0342201
01-27-69	0A11512 26	RX-3-2502A	TERPIN HYDRATE&CODEINE		1P3D	120 020A1016	2.85	2.80	01	0342202
01-27-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.40	01	0378820
01-27-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		0343289
01-20-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		0379221
01-20-69	0A11512 26	RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		0332952
01-13-69	0A11512 26	RX-3-2612C	AMITRIPTYLINE TABLET	25MG	1PC	50 020A1016	5.90	5.90		0340274
01-13-69	0A11512 26	RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		0373687

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01-13-69	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T2D	20 0A12340	3.15	3.15		0373688
01-07-69	0A6222	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T0H	24 020A1016	3.30	3.30		0363313
12-30-68	0A6222	26 RX-3-2612B	AMITRIPTYLINE TABLET	10MG	1PC	36 020A1016	3.60	3.60		0281379
12-23-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		0220099
12-23-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	APC	20 0A12340	3.15	3.15		0220100
12-11-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		0220397
12-11-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		0220396
12-04-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1650161
12-04-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T2D	20 0A12340	3.15	3.15		1650160
12-02-68	0A6222	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	12 020A1016	2.55	2.50	01	0313309
12-02-68	0A6222	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	APC	15 020A1016	2.90	2.90		0310733
11-27-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		1638363
11-27-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1638362
11-20-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		1637923
11-20-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1637916
11-15-68	0A6222	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	15 0R98700	2.60	2.60		1637917
11-15-68	0A6222	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	APC	15 0R98700	2.95	2.95		1637918
11-14-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		1637924
11-14-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1637922
11-11-68	0A6222	26 RX-3-2302B	COD,ASA,PHEN&CAFFEINE	1/4GR	10H	24 020A1016	2.85	2.85		1637919
11-09-68	0A12871	26 RX-3-8005C	CHLORPHENIRAMINE MAL TAB	4MG	1PH	50 020A1016	3.45	3.40	01	0330793
11-09-68	0A12871	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	12 020A546	2.50	2.50		1637090
11-06-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	10 0A12340	2.50	2.50		1637920
11-06-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1637921
10-30-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1693691
10-30-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	120	20 0A12340	3.15	3.15		1693690
10-29-68	0A11512	26 RX-3-0249H	TETRACYCLINE TAB-CAP	250MG	1PC	12 020A1016	2.85	2.85		1693689
10-29-68	0A11512	26 RX-3-8005C	CHLORPHENIRAMINE MAL TAB	4MG	1PC	50 020A1016	3.50	3.50		16936BB
10-25-68	0A12825	26 RX-3-26118	AMITRIPTYLINE&PERPHEN.	2-25	140	36 020A1016	5.90	5.75	01	1692777
10-23-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1693686
10-23-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	120	20 0A12340	3.15	3.15		1693687
10-18-68	0A12825	26 RX-3-0249H	TETRACYCLINE TAB-CAP	250MG	140	12 020A1016	1.50	1.50		1693441
10-18-68	0A12825	26 RX-3-8005C	CHLORPHENIRAMINE MAL TAB	4MG	14D	50 020A1016	3.00	3.00		1693477
10-16-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1693697
10-16-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	120	20 0A12340	3.15	3.15		1693698
10-12-68	0A11090	26 RX-3-0249H	TETRACYCLINE TAB-CAP	250MG	130	16 0A1302B	3.00	3.00		1693685
10-11-68	0A10714	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1HS	12 020A1016	2.60	2.50	01	1652802
10-11-68	0A10714	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	APC	24 020A1016	3.30	3.30		1693694
10-09-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1693695
10-09-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1693696
10-05-68	0A11090	26 RX-3-2601K	PROCHLORPERAZINE SUSTAIN	15MG	120	14 0A1302B	4.40	4.30	01	1652801
10-02-68	0A11512	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	10 0A12340	2.50	2.50		1693693
10-02-68	0A11512	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	12D	20 0A12340	3.15	3.15		1693692
10-02-68	0A11702	26 RX-3-2155H	PENTOBARBITAL CAP	100MG	1LHS	6 0R98700	1.30	1.30		1693817
10-02-68	0A11702	26 RX-3-2302C	COD,ASA,PHEN&CAFFEINE	-GR	1T4H	12 0R98700	1.90	1.90		1693816
09-25-68	0A11512	26 RX-3-02155	PENTOBARBITAL		1LHS	10 0A12340	1.40	1.40		1693678
09-25-68	0A11512	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		12D	20 0A12340	2.15	2.15		1693679
09-24-68	0A6222	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		APC	24 020A1016	2.65	2.65		1693680
09-18-68	0A11512	26 RX-3-02155	PENTOBARBITAL		1LHS	10 0A12340	1.40	1.40		1693683
09-18-68	0A11512	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		APC	20 0A12340	2.15	2.15		1693684
09-11-68	0A11512	26 RX-3-02155	PENTOBARBITAL		1LHS	10 0A12340	1.40	1.40		1693676
09-11-68	0A11512	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		12D	20 0A12340	2.15	2.15		1693677
09-10-68	0A6222	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		APC	12 020A1016	1.90	1.90		1693682
09-05-68	0A12825	26 RX-3-02601	PROCHLORPERAZINE			15 020A1016	3.65	3.65		1653612
09-05-68	0A12825	26 RX-3-00170	SULFAMETHIZOLE		230	60 0C29035	6.05	6.05		1653577
09-04-68	0A11512	26 RX-3-02155	PENTOBARBITAL		1HS	10 0A12340	1.40	1.40		1522854
09-04-68	0A11512	26 RX-3-02302	COD,ASA,PHEN&CAFFEINE		120	20 0A12340	2.15	2.15		1522855
08-31-68	0A11090	26 RX-3-02601	PROCHLORPERAZINE		12D	10 0A13028	3.00	3.00		1522852
08-30-68	0A11090	26 RX-3-02601	PROCHLORPERAZINE		16H	4 0A13028	2.65	2.65		1522853
08-28-68	0A11512	26 RX-3-02155	PENTOBARBITAL		1HS	10 0A12340	1.40	1.40		1522857

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08-28-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	20	0A12340	2.15	2.15		1522856
08-23-68	0A11090 26	RX-3-09560	HYDROCORT./A.B.	203D	5	0A13028	3.20	3.15	01	1522844
08-21-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	10	0A12340	1.40	1.40		1522858
08-21-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	20	0A12340	2.15	2.15		1522859
08-20-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1643681
08-06-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522861
08-06-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522860
07-29-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522863
07-29-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522862
07-27-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1460250
07-26-68	0A6222 26	RX-3-02601	PROCHLORPERAZINE	12D	24	020A1016	5.55	5.55		1522069
07-22-68	0A11512 26	RX-3-08005	CHLORPHENIRAMINE MALEATE	13D	50	020A1016	3.00	2.95	01	1465706
07-22-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522865
07-19-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522866
07-19-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	17D	24	020A1D16	2.65	2.45	01	1522845
07-17-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522868
07-17-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522867
07-15-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522870
07-15-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522869
07-11-68	0A12825 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.25	1.25		1522888
07-08-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522871
07-08-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522872
07-01-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522874
07-01-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522873
06-29-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522875
06-29-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	12	020A1016	1.90	1.80	01	1465787
06-24-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522692
06-24-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522693
06-23-68	0A12825 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	36	020A1016	2.05	2.05		1522886
06-21-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522694
06-17-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522696
06-17-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522695
06-15-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522697
06-14-68	0A12825 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	36	020A1016	2.05	2.05		1522882
06-14-68	0A12825 26	RX-3-08005	CHLORPHENIRAMINE MALEATE	13D	100	020A1016	5.00	4.75	01	1465918
06-10-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522698
06-10-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522699
06-07-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522700
06-07-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	36	020A1016	3.40	3.10	01	1522836
06-03-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522701
06-03-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522702
05-30-68	0A12825 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.25	1.25		1522889
05-27-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522704
05-27-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522703
05-27-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	35	020A1016	3.35	3.00	01	1522837
05-27-68	0A6222 26	RX-3-02612	ELAVIL	C3D	100	020A1016	11.95	11.95		1589609
05-25-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522705
05-22-68	0A12825 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	50	020A1016	2.75	2.75		1522881
05-20-68	0A11512 26	RX-3-02612	ELAVIL	13D	50	020A1016	6.25	6.25		1460260
05-20-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522707
05-20-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522706
05-18-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1622355
05-13-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522709
05-13-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522710
05-10-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522711
05-10-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	50	020A1016	4.30	3.85	01	1522838
05-06-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522713
05-06-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522712
05-03-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522714
05-03-68	0A6222 26	RX-3-08005	CHLORPHENIRAMINE MALEATE	13D	50	020A1016	3.00	3.00		1460262

Date of Service	Vendor No. & Type	Procedure or Diagnosis Code	Name	M.D.'s Pres. Order (How to Take)	Frequency	Prescriber's License	Billed	Paid	Review	Code No.
04-29-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522715
04-29-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522724
04-27-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.50		1522716
04-26-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	50	020A1016	2.95	2.95		1522717
04-24-68	0A6222 26	RX-3-02612	ELAVIL	1PH	100	020A1016	11.95	11.95		1425917
04-22-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522719
04-22-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522718
04-20-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.55	1.45	01	1522839
04-18-68	0A6222 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	50	020A1016	2.95	2.90	01	1522840
04-18-68	0A6222 26	RX-3-08005	CHLORPHENIRAMINE MALEATE	1PH	50	020A1016	3.00	2.95	01	1589229
04-15-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522720
04-15-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522721
04-13-68	0A6222 26	RX-3-02155	PENTOBARBITAL	1HS	12	020A1016	1.50	1.45	01	1522841
04-12-68	0A6222 26	RX-3-02612	ELAVIL	1PH	50	020A1016	6.55	6.55		1425914
04-08-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522722
04-08-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522723
04-07-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	10H	12	020A1016	1.75	1.75		1522725
04-02-68	0A11512 26	RX-3-02155	PENTOBARBITAL	1HS	15	0A12340	1.50	1.50		1522727
04-02-68	0A11512 26	RX-3-02302	COD,ASA,PHEN&CAFFEINE	12D	12	0A12340	1.75	1.75		1522726

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 444

CBS NO. ZZZ41794Z — PROVIDER NAME — PROVIDER NO. Z41794 — PROVIDER CODE 20

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV FEE UT	REJ COM
2-00101		I & D SEBACEOUS CYST	1	2.00	9.00	6.00	18.00		12.00	6.00		
2-00108		I & D ABSCESS	15	30.00	9.00	6.00	270.00		180.00	90.00	3	1
2-00130		INC-REM FB	7	14.00	8.14	6.00	114.00		84.00	24.00	1	1
2-00177		EXC LESION	1	6.00	3.00	3.00	18.00		18.00			
2-00178		EXC LESION EXT	2	13.00	6.00	6.00	78.00		78.00			
2-00190		EXC LESION & CLOSURE	1	10.00	7.80	5.00	78.00		50.00	28.00		
2-00225		AVULSION NAIL	1	2.00	9.00	6.00	18.00		12.00	6.00		
2-00238	20%	EXC CYST OR SINUS	1	6.00	7.00	7.00	42.00		42.00			
2-00251		REPAIR WOUND	13	26.00	8.77	6.23	228.00		162.00	66.00	2	
2-00260		REPAIR WOUND COMPLEX	5	40.00	3.70	3.70	148.00		148.00			
2-00263		REPAIR WOUND COMPLEX	1	10.00	3.00	3.00	30.00		30.00			
2-00270		PLASTIC REPAIR EXT	1	16.67	6.00	6.00	100.00		100.00			
2-00351		BURN, 1ST DEGREE	6	9.00	9.33	6.00	84.00		54.00	30.00		
2-00354		DRESS BURNS SMALL	6	12.00	7.00	6.00	84.00		72.00	12.00		
2-00405		ELECTRO SURGICAL	15	30.00	9.00	6.00	270.00		180.00	90.00	3	
2-00741		FX CLAVICLE CL	1	15.00	6.00	6.00	90.00		90.00			
2-00799		FX RADIUS, HEAD CL	1	15.00	6.00	6.00	90.00		90.00			
2-00815		FX ULNA, SHAFT CL	2	40.00	6.00	6.00	240.00		240.00			
2-00840		FX METACARPAL	1	5.00	6.00	6.00	30.00		30.00			
2-00842		FX METACARPAL-ONE	2	20.00	6.00	6.00	120.00		120.00			
2-00856		FX PHALANX, DISTAL	2	8.67	6.00	3.11	52.00		27.00	25.00		
2-00981		FX PHALANX-OTHER CL	1	5.00	6.00	6.00	30.00		30.00			
2-01378	20%	DISLOC METATARSAL OP	1	5.00	9.00	6.00	45.00		30.00	15.00		
2-01737		AMP DIGIT	1	15.00	6.00	6.00	90.00		90.00			
2-01851		FOREARM SPLINT	1	2.00	12.50	9.00	25.00		18.00	7.00	1	
2-01856		GAUNTLET CAST	1	2.00	9.00	6.00	18.00		12.00	6.00	1	
2-01865		SHORT LEG CAST	1	3.00	15.00	6.00	45.00		18.00	27.00	1	
2-01871		WALKING BOOT CAST	1	3.50	6.00	6.00	21.00		21.00			
2-01971		ANTERIOR NASAL PACKS	1	2.00	9.00	6.00	18.00		12.00	6.00		
2-01973		POST-PACK & CAUTERY	1	10.00	1.80	1.80	18.00		18.00			
2-02562	20%	LIG/DIV VEINS BILAT	1	10.00	7.80	6.00	78.00		60.00	18.00		
2-02992		TONSILLECTOMY	139	2,085.00	6.03	5.96	12,580.00	35.00	12,385.00	160.00		
2-02993		ADULT TONSIL,	8	160.00	6.00	5.81	960.00		930.00	30.00	1	
2-03261	20%	APPENDECTOMY	2	16.00	6.25	6.00	100.00		96.00	4.00	1	
2-03371		FISSURECTOMY	2	40.00	3.00		120.00			120.00		2
2-03374		PAPILLECTOMY	1	3.00	3.00		9.00			9.00		1
2-03380		HEMORRHOIDECTOMY	1	30.00	6.00	6.00	180.00		180.00			
2-03382		FISTULOTOMY	1	40.00	6.00	6.00	240.00		240.00			
2-03515	20%	CHOLECYSTECTOMY	5	60.00	6.57	6.00	394.00		360.00	34.00	4	
2-03635	20%	HERNIORRHAPHY	1	8.00	6.50	6.00	52.00		48.00	4.00		
2-03663	20%	HERNIORRHAPHY	1	7.00	6.50	6.00	45.50		42.00	3.50		
2-04122		CIRCUMCISION	7	21.00	6.00	6.00	126.00		126.00			
2-04123	50%	CIRCUMCISION	1	2.50	6.00	6.00	15.00		15.00			
2-04124		CIRCUMCISION	2	20.00	6.00	6.00	120.00	50.00	70.00			
2-04241		VASECTOMY	9	135.00	6.00	5.78	810.00		780.00	30.00		
2-04405		I & D CYST	1	5.00	6.00	6.00	30.00		30.00			
2-04531	20%	TRANSECTION TUBE	3	24.00	6.75	6.00	162.00		144.00	18.00		
2-04532	20%	TRANSECTION TUBE	1	6.00	7.00	7.00	42.00		42.00			
2-04573		BIOPSY CERVICAL CONE	3	60.00	6.00	6.00	360.00		360.00			

CBS NO. ZZZ41794Z PROVIDER NAME PROVIDER NO. Z41794 PROVIDER CODE 20

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV UT	FEE	REJ	COM
2-04583		IUD INSERTION	8	24.00	7.75	6.00	186.00		144.00	42.00		1		
2-04589		D & C CERVICAL CANAL	1	15.00	6.00	6.00	90.00		90.00					
2-04612		D & C	9	135.00	6.00	6.00	810.00		810.00					
2-04614	20%	TOTAL HYSTERECTOMY	2	24.00	6.67	6.00	160.00		144.00	16.00		1		
2-04821		TOTAL OB CARE	15	525.00	5.73	5.69	3,010.00		2,986.00	24.00		1		
2-04822		OB DELIVERY	1	20.00	5.25	5.25	105.00		105.00					
2-04823		ANTERPARTUM	5	40.58	6.00	6.00	243.50		243.50					
2-05901		I & D ABSCESS/HEMA	1	2.00	9.00	6.00	18.00		12.00	6.00				
2-05931		OTOSCOPY	2	4.00	9.00	6.00	36.00		24.00	12.00				
2-08477		SMEAR UNSTAINED	11	6.60	5.00	3.18	33.00		21.00	12.00			1	
2-08911		PAP SMEAR	2	2.00	6.00	3.00	12.00		6.00	6.00				
2-08956		URINE MICRO ONLY	82	24.60	5.06	5.06	124.50		124.50					
2-09000		INITIAL OFFICE VISIT	1027	2,056.58	5.99	5.96	12,324.50		12,253.00	71.50	1	1		
2-09003		FOLLOW-UP OFF. VISIT	9	7.20	7.01	5.68	50.50		40.90	9.60		8		
2-09004		OFFICE VISIT	7006	7,006.00	6.02	5.55	42,174.50	93.00	38,805.30	3,258.20	133	10	369	88
2-09005		FOLLOW-UP OFF. VISIT	3	4.50	6.00	5.33	27.00		24.00	3.00				
2-09006		FOLLOW-UP PROLONGED	1	2.00	6.00	6.00	12.00		12.00					
2-09010		HOME VISIT, INITIAL	8	20.00	6.00	6.00	120.00		120.00					
2-09014		HOME VISIT	87	174.00	5.93	5.88	1,032.00		1,023.00	9.00				
2-09018		HOME VISIT, FAMILY	11	11.00	7.09	6.00	78.00		66.00	12.00				
2-09019		NURSINGHOME&CONV HOSPITAL	13	39.00	4.00	4.00	156.00		156.00					
2-09020		HOSP VISIT,INITIAL	21	63.00	6.00	5.62	378.00	36.00	318.00	24.00		1	1	
2-09024		HOSPITAL VISIT	107	107.00	6.00	5.89	642.00	48.00	582.00	12.00			2	
2-09026		HOSPOUTPATIENT&EMERGENCY	7	21.00	6.00	5.14	126.00		108.00	18.00		2		
2-09035		NEWBORN CARE HOSP	8	40.00	6.00	6.00	240.00		240.00					
2-09040		IMMUNIZATION	26	26.00	3.56	3.54	92.50		92.10	.40		2		
2-09071		DETENTION	1	5.00	6.00	6.00	30.00		30.00					
2-09073		NIGHT CALL	2	2.00	6.00	5.50	12.00		11.00	1.00				
2-09075		SPECIAL REPORTS	3	6.00	6.00	6.00	36.00		36.00					
2-09101		EKG	1	3.00	6.00	6.00	18.00		18.00					
2-09103		E.C.G. READING	49	73.50	6.00	6.00	441.00		441.00					
2-09440		PHYSIOTHERAPY	55	55.00	6.11	6.11	336.00		336.00					
2-09900		INJECTIONS	2251	2,251.00	2.75	2.46	6,183.34	1.00	5,526.19	653.65	29	6	191	111
2-09988		DRESSINGS&MATERIALS	17	17.00	2.03	2.03	34.55		34.55					
2-A0005		DPT	40	21.25	6.01	6.01	127.80		127.80					
2-A0010		FLU	51	24.20	6.01	6.01	145.50		145.50					
2-A0025		MEASLES RUBEOVAX	16	10.33	6.00	6.00	62.00		62.00					
2-A0030		MUMPS	9	9.00	6.00	6.00	54.00		54.00					
2-A0035		ORIMUNE	1	.42	5.95		2.50			2.50			1	
2-A0040		POLIO	11	4.33	6.03	4.87	26.10		21.10	5.00			2	
2-A0045		SMALL POX	17	7.07	6.01	6.01	42.50		42.50					
2-A0050		TETANUS	1	.50	6.00	6.00	3.00		3.00					
2-A0110		ALLERGIN	1	.33	6.06	6.06	2.00		2.00					
2-A0215		AMINOPHYLLINE	16	8.60	6.05	5.41	52.00		46.50	5.50		3		
2-A0225		BENADRYL	2	.84	5.95	2.98	5.00		2.50	2.50	1			
2-A0235		BICILLIN	2	8.32	6.01		50.00			50.00			2	
2-A0255		CHLOR-TRIMETON	27	11.20	6.00	3.10	67.25		34.75	32.50	5		8	
2-A0270		COMPAZINE	1	.58	6.03	6.03	3.50		3.50					
2-A0300		DEMEROL	24	13.92	6.03	3.27	84.00	3.00	42.50	38.50	6	2	3	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 446

CBS NO. ZZZ41794Z PROVIDER NAME — PROVIDER NO. Z41794 — PROVIDER CODE 20

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV UT	FEE	REJ	COM
2-A0320		DESOXYCORTICOSTERONE	207	116.57	6.03	2.71	702.50		316.00	386.50	23	1	90	3
2-A0335		ESTROGEN	261	110.96	5.86	3.76	650.25		417.75	230.00	33		58	19
2-A0360		INTERON	57	35.23	5.82	4.31	204.90		152.00	52.90	2	8	6	
2-A0385		MERALURIDE	25	12.50	6.00	5.04	75.00		63.00	12.00	3		1	
2-A0395		METHOTREXATE	2	1.00	6.00	6.00	6.00		6.00					
2-A0515		PENICILLIN	1182	491.82	6.02	4.47	2,960.75	3.00	2,193.75	759.00	78	10	211	2
2-A0520		PENTOBARBITAL	92	39.14	5.98	3.10	234.25		121.25	113.00	13	1	31	
2-A0575		TBA	1	.42	5.95	5.95	2.50		2.50					
2-A0580		TERRAMYCIN	67	33.35	6.00	3.48	200.20		116.20	84.00	6		22	4
2-A0585		TESTOSTERONE	32	18.00	6.03	3.25	108.50		58.50	50.00	6		8	
2-A0595		TET-TOX	22	11.16	6.00	5.73	67.00		64.00	3.00			1	
2-A0620		VISTARIL	1	.42	5.95		2.50			2.50			1	
4-09988		MISC MATERIALS	14	50.18	.43	.43	21.50		21.50					

1 injection to each 1.8 office or home visits

TOTAL UNITS BILLED	16,964.54	TOTAL ITEMS OVERUTIL	308	COMM	31
AVERAGE BILLED UNIT COST	5.56	TOTAL ITEMS FEE	71	COMM	5
AVERAGE PAID UNIT COST	5.15	TOTAL ITEMS REJECT	819	COMM	193
TOTAL AMOUNT BILLED	94,270.39	TOTAL PAID BY OTHER INS		269.00	
TOTAL PAID OTHER	269.00	TOTAL PAID BY PATIENT			
TOTAL PAID BY MEDI-CAL	87,079.14	TOTAL NOT PAID			
TOTAL ADJUST AMOUNT	6,888.25	TOTAL PAID BY MEDICARE			
TOTAL OVERUTIL ADJUST	1,185.00	TOTAL OVERUTIL ADJ COMM		117.50	
TOTAL FEE ADJUST	352.60	TOTAL FEE ADJUST COMM		16.35	
TOTAL REJECTS	3,389.75	TOTAL REJECTS COMM		802.65	
TOTAL REVIEW DESK ADJ	1,024.40	TOTAL TARS DISAPPROVED			

CBS NO. 00C199870 PROVIDER NAME PROVIDER NO. 0C19987 PROVIDER CODE 20

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV FEE REV COM UT
2-00101		I & D SEBACEOUS CYST	2	4.00	6.50	6.00	26.00		24.00	2.00	
2-00108		I & D ABSCESS	6	12.00	6.83	6.00	82.00		72.00	10.00	
2-00130		INC-REM FB	2	4.00	6.50	6.00	26.00		24.00	2.00	
2-00131		INC-REM FB COMPL	1	2.00	6.00	6.00	12.00		12.00		
2-00145		ASPIRATION	1	1.00	7.00	6.00	7.00		6.00	1.00	
2-00225		AVULSION NAIL	1	2.00	6.00	6.00	12.00		12.00		
2-00228		EXC NAIL OR MATRIX	3	30.00	5.13	4.47	154.00		134.00	20.00	1
2-00251		REPAIR WOUND	5	10.00	7.95	6.00	79.50		60.00	19.50	1
2-00260		REPAIR WOUND COMPLEX	5	40.00	6.48	4.40	259.00		176.00	83.00	3
2-00354		DRESS BURNS SMALL	5	10.00	5.80	5.40	58.00		54.00	4.00	2
2-00355		DRESS BURNS MEDIUM	3	9.00	4.00	4.00	36.00		36.00		
2-00405		ELECTRO SURGICAL	4	8.00	7.94	6.00	63.50		48.00	15.50	
2-01046		INJ INTO JOINT	3	6.00	7.17	6.00	43.00		36.00	7.00	
2-01413		NEEDLE PNCT. BURSA	1	2.00	10.50	9.00	21.00		18.00	3.00	
2-01495		SUTURE DIAPH.	1	14.00	6.00	6.00	84.00		84.00		
2-01498	20%	VAGOTOMY&PYLOROPLASTY&HER	1	16.00	6.75	6.00	108.00		96.00	12.00	
2-01856		GAUNTLET CAST	1	2.00	7.00	6.00	14.00		12.00	2.00	
2-01865		SHORT LEG CAST	1	3.00	7.00	6.00	21.00		18.00	3.00	1
2-02394	20%	THROMBOENDARTERECT	1	24.00	7.00	5.17	168.00		124.00	44.00	1
2-03515	20%	CHOLECYSTECTOMY	4	48.00	6.25	6.00	300.00		288.00	12.00	
2-03631	20%	HERNIORRHAPHY	1	7.00	6.86	6.00	48.00		42.00	6.00	
2-04122		CIRCUMCISION	4	12.00	8.33	6.58	100.00		79.00	21.00	
2-04123		CIRCUMCISION	1	5.00	5.00	5.00	25.00		25.00		
2-04479		COLPORRHAPHY	1	6.00	6.00	6.00	36.00		36.00		
2-04481	20%	COLPORRHAPHY	1	7.00	7.14	6.00	50.00		42.00	8.00	1
2-04612	20%	D & C	2	6.00	18.00	16.50	108.00		99.00	9.00	1
2-04614	20%	TOTAL HYSTERECTOMY	2	24.00	7.50	6.75	180.00		162.00	18.00	
2-04821		TOTAL OB CARE	9	315.00	6.22	5.84	1,960.00		1,840.00	120.00	
2-04851		ABORTION-COMPL.SURG	1	15.00	8.00	6.00	120.00		90.00	30.00	
2-04870		POSTPARTUM D&C	1	15.00	6.00	6.00	90.00		90.00		
2-05931		OTOSCOPY	1	2.00	7.00	6.00	14.00		12.00	2.00	
2-07100		X-RAY CHEST	1	2.00	6.00	6.00	12.00		12.00		
2-07101		X-RAY CHEST	125	387.00	5.52	5.52	2,136.00		2,136.00		
2-07252		X-RAY ELBOW	1	2.00	6.00	5.50	12.00		11.00	1.00	
2-07255		X-RAY FOREARM	1	2.00	6.00	6.00	12.00		12.00		
2-07259		X-RAY HAND	6	12.00	6.67	5.83	80.00		70.00	10.00	
2-07305		X-RAY KNEE	1	3.00	7.33	5.50	22.00		16.50	5.50	
2-07306		X-RAY LEG	2	4.00	7.63	5.75	30.50		23.00	7.50	
2-07309		X-RAY FOOT	6	12.00	6.67	5.83	80.00		70.00	10.00	
2-07475		SPECIAL EXAM	1	1.00	5.50	5.50	5.50		5.50		
2-08555		MISCELLANEOUS	4	5.48	5.99	5.99	32.80		32.80		
2-08611		BILIRUBIN	4	4.00	7.00	6.00	28.00		24.00	4.00	1
2-08622		HEMOGLOBIN	61	24.40	7.33	5.98	178.80		146.00	32.80	7
2-08652		CHOLESTEROL	11	11.00	7.00	6.00	77.00		66.00	11.00	2
2-08722		GLUCOSE	74	74.00	7.00	6.00	518.00		444.00	74.00	11
2-08734		TOTAL PROTEIN	1	1.00	7.00	6.00	7.00		6.00	1.00	
2-08735		PROTEIN A/G	3	6.00	7.00	6.00	42.00		36.00	6.00	1
2-08745		UREA BUN	54	54.00	6.94	5.95	374.50		321.50	53.00	6
2-08747		URIC ACID	1	1.00	7.00	6.00	7.00		6.00	1.00	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 284

CBS NO. 00C199870 PROVIDER NAME — PROVIDER NO. 0C19987 — PROVIDER CODE 20

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV UT	FEE	REJ	COM
2-08911		PAP SMEAR	11	11.00	5.55	1.45	61.00		16.00	45.00				
2-08936		URINALYSIS ROUTINE	64	32.00	4.00	4.00	128.00		128.00					
2-08955		URINE ROUT CHEM	4	1.20	6.67	6.00	8.00		7.20	.80				
2-09000		INITIAL OFFICE VISIT	257	514.00	5.97	5.88	3,071.00		3,024.00	47.00			1	
2-09003		FOLLOW-UP OFF. VISIT	10	8.00	7.38	5.90	59.00		47.20	11.80		9		
2-09004		OFFICE VISIT	2727	2,727.00	6.87	5.97	18,743.00		16,283.50	2,456.50	2	157	11	3
2-09005		FOLLOW-UP OFF. VISIT	121	181.50	6.21	5.02	1,128.00		910.50	217.50		2		
2-09014		HOME VISIT	2	4.00	7.25	7.50	33.00		30.00	3.00				
2-09020		HOSP VISIT,INITIAL	17	51.00	6.73	4.88	343.00		249.00	94.00		3	2	
2-09021		HOSP VISIT-HIST/EXAM	1	5.00	7.00	6.00	35.00		30.00	5.00		1		
2-09022		HOSP VISIT-HIST/EXAM	1	6.00	5.83	5.83	35.00		35.00					
2-09024		HOSPITAL VISIT	109	109.00	7.94	5.60	865.00		610.00	255.00		31	4	
2-09026		HOSPOUTPATIENT&EMERGENCY	4	12.00	6.08	5.25	73.00		63.00	10.00		1		
2-09028		LIMITED CONSULT	1	3.00	7.00	6.00	21.00		18.00	3.00				
2-09035		NEWBORN CARE HOSP	3	15.00	1.67	1.67	25.00		25.00					
2-09040		IMMUNIZATION	2	2.00	4.00	4.00	8.00		8.00					
2-09075		SPECIAL REPORTS	1	1.37	6.02	6.02	8.25		8.25					
2-09101		EKG	30	90.00	6.17	5.74	555.00		517.00	38.00		3		
2-09206		PULMONARY TEST	6	30.00	7.00	6.00	210.00		180.00	30.00		2		
2-09320		SKIN TEST	18	18.00	4.10	4.10	73.80		73.80					
2-09440		PHYSIOTHERAPY	4	4.00	7.00	6.00	28.00		24.00	4.00		1		
2-09900		INJECTIONS	281	281.00	4.57	4.49	1,283.50		1,262.50	21.00		4		
2-09988		DRESSINGS&MATERIALS	4	4.00	2.06	2.06	8.25		8.25					
2-A0010		FLU	1	.83	6.02	6.02	5.00		5.00					
2-A0025		MEASLES RUBEOVAX	1	.83	6.02	6.02	5.00		5.00					
2-A0040		POLIO	1	.83	6.02	6.02	5.00		5.00					
2-A0050		TETANUS	1	.83	6.02	6.02	5.00		5.00					
2-A0110		ALLERGIN	2	1.66	6.02	6.02	10.00		10.00					
2-A0205		ADRENALIN	4	3.32	6.02	6.02	20.00		20.00					
2-A0210		ADRENALIN IN OIL	2	1.66	6.02	6.02	10.00		10.00					
2-A0225		BENADRYL	1	.83	6.02	6.02	5.00		5.00					
2-A0235		BICILLIN	6	4.98	6.02	6.02	30.00		30.00					
2-A0270		COMPAZINE	4	3.32	6.02	6.02	20.00		20.00					
2-A0280		DECADRON	2	1.66	6.02	6.02	10.00		10.00					
2-A0300		DEMEROL	20	16.60	6.02	5.72	100.00		95.00	5.00	1			
2-A0305		DEPO-MEDROL	2	1.66	6.02	6.02	10.00		10.00					
2-A0330		ERGOTRATE	1	.83	6.02	6.02	5.00		5.00					
2-A0360		IMFERON	5	4.15	6.02	6.02	25.00		25.00					
2-A0375		LINCOCIN	12	9.96	6.02	6.02	60.00		60.00					
2-A0390		MERCUHYDRIN	20	16.60	6.02	6.02	100.00		100.00					
2-A0515		PENICILLIN	159	132.31	6.02	5.43	797.00		719.00	78.00	4		11	
2-A0520		PENTOBARBITAL	1	.83	6.02	6.02	5.00		5.00					
2-A0580		TERRAMYCIN	3	2.49	6.02	6.02	15.00		15.00					
2-A0595		TET-TOX	16	12.78	6.03	6.03	77.00		77.00					
4-09988		MISC MATERIALS	1	1.25	6.00	6.00	7.50		7.50					

1 injection to each 5.7 office or home visits

TOTAL UNITS BILLED	5,597.16	TOTAL ITEMS OVERUTIL	7	COMM	
AVERAGE BILLED UNIT COST	6.45	TOTAL ITEMS FEE	250	COMM	3
AVERAGE PAID UNIT COST	5.73	TOTAL ITEMS REJECT	29	COMM	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE TOTALS — DATE 04/02/69 — PAGE NO. 285

CBS NO. 00C199870 PROVIDER NAME — PROVIDER NO. 0C19987 — PROVIDER CODE 20

TOTAL AMOUNT BILLED	36,089.40	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	32,091.00	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	3,995.40	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST	39.00	TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST	605.30	TOTAL FEE ADJUST COMM	3.00
TOTAL REJECTS	219.00	TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ	3,129.10	TOTAL TARS DISAPPROVED	

This doctor brought to Committee 1967. No problem now. BUT see next report - his drug prescriber profile.

PRESCRIBER PROFILE

PRESCRIBER LICENSE NO. 0C19987 CBS 00C199870 MONTH ENDING 04/03/69 PAGE NO. 641

DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
00020	ISONIAZID	*	1	1	4	2.20	2.20	5	7	604	19.15	19.15
00061	METHENAMINE MAND. TAB		0	0		0.00	0.00	23	27	1,370	139.85	138.20
00080	NITROFURANTOIN	*	0	0		0.00	0.00	3	8	415	168.00	166.70
00081	NITROFURAZONE VAG SUPPOS		8	8	192	63.80	57.40	68	73	1,613	498.95	485.35
00106	TRISULFAPYRIMIDINES		1	1	60	1.80	1.80	2	2	63	4.05	4.05
00163	SULFISOXAZOLE		0	0		0.00	0.00	5	5	55	12.95	12.95
00164	SULFISOXAZOLE&PHENAZOPY.		3	3	180	13.75	13.75	47	49	2,694	225.35	225.25
00180	NEOMYCIN/KAOPECTATE		4	4	132	13.50	13.50	44	46	524	152.19	151.74
00205	PEN G TAB	200,000U	0	0		0.00	0.00	1	1	1	3.85	3.85
00206	PEN G TAB	250,000U	0	0		0.00	0.00	2	2	32	5.75	5.75
00207	PEN G TAB	400,000U	1	1	18	1.95	1.90	2	2	38	3.95	3.90
00208	PEN G TAB	500,000U	0	0		0.00	0.00	2	2	44	4.20	4.20
00209	PEN V (K)		0	0		0.00	0.00	2	2	2	7.25	7.25
0020C	ISONIAZID TAB	* 100MG	0	0		0.00	0.00	7	9	900	30.15	29.70
00210	PHENETHICILLIN		0	0		0.00	0.00	2	2	6	13.70	13.70
00222	LINCOCIN	*	1	1	2	3.90	3.90	11	12	89	58.95	58.95
00240	BENZATHINE PEN G INJ.		0	0		0.00	0.00	5	6	66	22.95	22.30
00241	CHLORTETRACYCLINE		0	0		0.00	0.00	1	1	16	3.85	3.85
00242	OXYTETRACYCLINE		0	0		0.00	0.00	2	2	21	7.80	7.80
00244	TETRACYCLINE	OTHERFORM	0	0		0.00	0.00	5	5	58	18.25	18.25
00245	TETRACYCLINE	100MG	0	0		0.00	0.00	3	3	40	7.55	7.55
00246	TETRACYCLINE	250MG	23	37	572	134.70	134.45	276	417	6,164	1,394.62	1,389.58
00247	DEMETHYLCHLORTETRACYCLINE		42	44	395	157.65	153.35	323	350	2,103	1,275.15	1,263.17
00248	TETRACYCLINE	SUSP-SYRUP	0	0		0.00	0.00	3	3	6	8.10	8.10
00249	TETRACYCLINE,NYST,-AMPHOT.		0	0		0.00	0.00	1	1	15	4.80	4.80
00262	CHLORAMPHENICOL		0	0		0.00	0.00	2	2	2d	10.20	10.20
00265	ERYTHROMYCIN		6	6	149	22.40	21.55	117	122	1,639	536.30	528.90
00277	NYSTATIN		0	0		0.00	0.00	3	3	62	22.05	19.55
00289	GRISEOFULVIN TAB OR CAP	*	2	2	65	12.35	12.35	17	22	6,025	203.10	199.75
0061B	METHENAMINE MAND. TAB	.5GM	0	0		0.00	0.00	1	1	60	4.40	4.40
0061C	METHENAMINE MAND. TAB	1.0GM	0	0		0.00	0.00	11	12	636	63.30	63.25
00630	DIODOQUIN VAG.TAB		0	0		0.00	0.00	1	1	1	4.45	4.45
0064A	METHENAMINE HIPPURATE	1GM	1	1	60	7.10	7.10	1	1	60	7.10	7.10
0080C	NITROFURANTOIN TAB	* 100MG	0	0		0.00	0.00	2	2	32	13.90	13.90
0080D	NITROFURANTOIN LIQ	* 5MG/CC	0	0		0.00	0.00	1	1	2	3.85	3.85
00850	PIPERAZINE CITRATE		0	0		0.00	0.00	1	1	3	2.35	2.35
00851	PYRVIUM PAMOATE		0	0		0.00	0.00	1	1	9	3.25	3.25
01007	ISOPROTERNOL HCL		1	7	42	58.45	58.45	15	83	341	545.05	544.90
01008	ISOPROTERNOL SULFATE		0	0		0.00	0.00	1	1	1	5.95	5.95
01010	DUO-MEDIHALER		2	3	4	25.05	25.05	14	47	57	364.25	360.80
01033	PHENYLEPHRINE HCL		1	1	12	2.00	2.00	5	5	152	16.95	16.95
01034	PSEUDOEPHEDRINE		0	0		0.00	0.00	1	1	36	3.00	3.00
0106B	TRISULFAPYRIMIDINES	LIQ	0	0		0.00	0.00	1	1	60	2.75	2.75
01102	EPHEDRINE & AMOBARBITAL		3	3	172	8.55	8.55	40	73	7,924	329.32	328.62
01200	ERGONOVINE MALEATE		0	0		0.00	0.00	8	8	106	14.95	14.95
01403	PHOSPHOLINE IODIDE		0	0		0.00	0.00	1	1	1	3.85	3.85
01500	PILOCARPINE OPH OINT		0	0		0.00	0.00	5	5	33	14.05	14.05
01608	TRIHEXYPHENIDYL HCL		0	0		0.00	0.00	5	8	720	28.10	28.10
0163C	SULFISOXAZOLE TAB	0.5GM	1	1	50	4.40	4.40	1	1	50	4.40	4.40
0164A	SULFISOXAZOLE&PHENAZOPY.		17	18	940	80.82	80.82	39	42	2,194	189.98	187.82

DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
01702	BELLADONNA TINCTURE		0	0		0.00	0.00	3	3	122	7.30	7.30
01704	DICYCLOMINE HCL		0	0		0.00	0.00	1	2	200	14.30	14.30
01711	METHSCOPOLAMINE BR/PB		0	0		0.00	0.00	2	2	2	5.00	5.00
01712	OXYPHENCYCLIMINE HCL		0	0		0.00	0.00	19	21	1,534	172.21	172.21
01717	PROPANTHELINE BROMIDE		6	6	640	44.85	44.30	45	64	6,871	483.25	479.70
01800	BELLADONNA ALKALOIDS&BARB		7	7	664	23.65	23.65	157	256	19,457	723.39	714.14
01801	BELL.ALK.ERGOT.TART&BARB. TABLETS		2	2	220	15.80	15.65	14	15	1,470	111.90	108.95
01803	BELL.ALK.&BARB./ANTACID		1	1	50	3.20	3.20	12	17	1,608	85.75	85.10
01804	DONNAGEL P.G.		1	1	4	2.45	2.45	1	1	4	2.45	2.45
01805	DONNAGEL/NEOMYCIN		0	0		0.00	0.00	1	1	200	9.25	9.25
0180A	NEOMYCIN/PROTECTIVE		5	5	540	17.05	17.05	15	16	700	59.45	58.55
01920	BILE ACID&OR SALTS/SED.		0	0		0.00	0.00	1	1	60	6.00	6.00
02024	MEPERIDINE HCL		2	2	36	4.65	4.65	35	48	1,075	158.35	149.90
02036	SOD SALICYLATE		4	4	524	8.40	8.40	30	42	5,308	80.69	77.23
0204D	PEN G TAB	400,000U	0	0		0.00	0.00	1	1	36	3.20	3.20
0204E	PEN G TAB	500,000U	0	0		0.00	0.00	1	1	28	3.40	3.40
02074	CODEINE PO4 OR SO4		0	0		0.00	0.00	5	7	170	20.50	20.50
02090	PERCODAN		0	0		0.00	0.00	2	2	36	5.20	5.20
02151	AMOBARBITAL SOD.		0	0		0.00	0.00	1	3	54	5.60	5.55
02153	BUTABARBITAL SODIUM		0	0		0.00	0.00	10	11	390	27.90	27.90
02155	PENTOBARBITAL		3	4	102	7.45	7.30	36	64	1,714	137.01	136.78
02156	PHENOBARBITAL		5	7	720	13.45	13.30	63	98	10,134	186.31	182.76
0221E	AMPICILLIN TAB OR CAP	* 250MG	1	1	16	5.90	5.90	1	1	16	5.90	5.90
0222D	LINCOMYCIN CAP	* 500MG	4	5	67	29.60	29.60	19	23	265	124.75	124.55
0222F	LINCOMYCIN LIQUID	* 250MG/5CC	1	1	60	4.15	4.15	7	8	190	33.66	33.45
02250	CHLORAL HYDRATE		1	3	72	7.35	7.35	4	10	276	28.30	28.20
02251	GLUTETHIMIDE		1	2	60	5.90	5.90	4	10	300	29.50	29.50
02252	METHYPRYLON		2	2	60	7.50	7.50	37	55	1,729	218.55	212.45
02302	COD.ASA,PHEN&CAFFEINE		38	59	1,626	130.41	129.11	503	990	32,495	2,388.25	2,378.68
02407	DIPHENYLHYDANTOIN		2	2	150	6.60	5.00	45	62	6,146	181.50	179.20
0244H	TETRACYCLINE TAB-CAP	250MG	70	75	1,532	238.05	238.05	343	430	7,607	1,312.73	1,311.95
0244K	TETRACYCLINE LIQ	125MG/5CC	0	0		0.00	0.00	2	3	92	8.95	8.85
02502	TERPIN HYDRATE&CODEINE		0	0		0.00	0.00	12	13	333	29.00	28.95
02503	CHLORPHEN MAL COMPOUND		0	0		0.00	0.00	3	3	58	7.10	7.10
02505	BENYLIN EXPECTORANT		15	15	536	32.05	30.65	119	145	1,571	336.85	334.50
02506	PHENERGAN EXP. PLAIN		0	0		0.00	0.00	2	2	8	3.95	3.95
02507	PHENERGAN EXP/CODEINE		29	29	352	63.95	63.90	193	236	1,371	528.25	525.45
02508	PHENERGAN EXP PEDIATRIC		0	0		0.00	0.00	5	5	19	10.85	10.85
02509	CHERACOL LIQUID		0	0		0.00	0.00	2	2	12	4.90	4.90
02510	KI SAT. SOLN		10	10	67	15.06	15.01	97	107	456	166.29	165.39
02512	TOCLONOL		0	0		0.00	0.00	1	1	100	11.05	11.05
02514	PHENERGAN EXP VC/CODEINE		0	0		0.00	0.00	1	1	4	2.45	2.45
02517	CEROSE		0	0		0.00	0.00	1	1	4	2.15	2.15
02530	TRIPELENNAMINE EXP/EPHED		4	4	136	9.85	9.85	40	41	638	92.20	92.15
02531	TRIPELEN EXP/EPHED&COD.		1	1	3	3.40	2.15	46	52	286	133.88	131.65
0253B	TRIACETYLOLEANDOMYCIN CAP	250MG	12	14	200	76.10	76.10	21	24	348	131.65	131.65
0253C	TRIACETYLOLEANDOMYCIN LIQ	125MG/CC	0	0		0.00	0.00	1	1	2	4.00	4.00
02600	CHLORPROMAZINE TAB&SPAN.		2	2	170	18.25	17.75	51	75	8,290	826.71	817.26
02601	PROCHLORPERAZINE		7	8	376	51.70	51.70	97	120	5,635	775.85	768.40
02603	MELLARIL		3	5	350	46.70	46.60	102	142	14,224	1,846.70	1,839.15

65 tablets per person - now being studied.

PRESCRIBER PROFILE

PRESCRIBER LICENSE NO. 0C19987 CBS 00C199870 MONTH ENDING 04/03/69 PAGE NO. 643

DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
02608	STELAZINE		0	0		0.00	0.00	3	3	260	30.85	30.70
02612	ELAVIL		11	14	1,290	155.30	155.30	103	136	12,747	1,517.51	1,515.00
02615	FLUPHENAZINE *		2	2	78	8.75	8.75	16	19	1,346	128.45	128.45
02641	RAUWOLFIA SERPENTINA	50MG	0	0		0.00	0.00	1	1	100	1.95	1.95
02642	RAUWOLFIA SERPENTINA	OTHERFORM	0	0		0.00	0.00	5	5	432	63.95	63.95
02645	RESERPINE TAB	0.1MG	0	0		0.00	0.00	1	1	100	1.90	1.90
02646	RESERPINE TAB	0.25MG	11	14	1,380	25.15	24.60	150	211	21,060	397.86	396.76
02648	RESERPINE TAB	1.0MG	0	0		0.00	0.00	2	2	130	3.30	3.30
0265J	ERYTHROMYCIN TAB-CAP	200MG	13	13	188	61.00	61.00	56	60	872	294.15	293.70
0265K	ERYTHROMYCIN TAB-CAP	250MG	26	29	452	165.95	165.90	75	87	1,312	486.40	485.30
0265N	ERYTHROMYCIN PED.DROPS	100MG/2.5C	0	0		0.00	0.00	1	1	1	3.55	3.55
0265P	ERYTHROMYCIN LIQUID 60CC	200MG/5CC	10	11	660	45.35	45.35	36	39	1,163	159.90	159.15
0265R	ERYTHROMYCIN LIQUID 90CC	200MG/5CC	1	1	90	4.65	4.65	3	4	93	18.75	18.75
0265T	ERYTHROMYCIN LIQUID 60CC	125MG/5CC	4	4	240	15.50	15.40	24	24	802	92.45	92.05
02718	ETHAMBUTOL TABLET	400MG	1	1	60	8.65	8.65	2	3	134	19.95	19.90
0277A	NYSTATIN TAB	200,000UN	0	0		0.00	0.00	3	3	70	14.35	14.35
0289B	GRISEOFULVIN TAB OR CAP *	250MG	0	0		0.00	0.00	6	6	360	57.40	55.35
0289C	GRISEOFULVIN TAB OR CAP *	500MG	0	0		0.00	0.00	1	1	30	2.70	2.70
02903	AMINOPHYLLINE ALL OTHERS		1	1	24	3.80	3.80	3	3	48	9.70	9.70
02905	AMINOPHYLLINE SUPP	0.5GM	1	1	24	4.55	4.55	21	26	399	89.50	89.25
0290A	TOLNAFTATE LIQ	1%-10CC	2	2	11	8.60	8.60	7	8	26	35.38	34.40
0290B	TOLNAFTATE CR	1%-15GM	2	3	45	13.80	13.80	3	4	46	18.10	18.10
02953	THEOPHYLLINE,EPHED&PB		4	5	358	21.15	21.15	42	55	4,274	283.30	282.95
02955	AMINO.& PENTOBARBITAL SOD		0	0		0.00	0.00	1	1	4	2.30	2.30
02960	THEOPHYLLINE,EPHED,PB&KI		0	0		0.00	0.00	1	1	100	6.85	6.85
03000	DIGITALIS		0	0		0.00	0.00	12	13	1,200	27.05	27.05
03001	DIGITOXIN.		0	0		0.00	0.00	2	8	240	13.20	13.20
03007	DIGOXIN		0	0		0.00	0.00	10	13	1,230	34.05	34.05
03103	QUINIDINE SULFATE	0.2GM	1	1	100	10.75	9.25	8	16	1,700	162.60	127.60
03104	QUINIDINE SULFATE	0.32GM	0	0		0.00	0.00	1	2	200	16.10	16.10
03307	METHYLDOPA		0	0		0.00	0.00	3	5	365	37.40	37.40
03309	PENTAERYTHRITOL TETRANIT.		0	0		0.00	0.00	10	15	1,830	122.05	120.30
03310	PENTOLINIUM TARTRATE		1	1	120	4.15	4.15	5	7	780	27.70	27.70
03311	NITROGLYCERIN		0	0		0.00	0.00	12	16	1,094	27.75	27.75
03500	ACETAZOLAMIDE		0	0		0.00	0.00	1	1	60	7.65	7.65
03501	CHLOROTHIAZIDE		0	0		0.00	0.00	2	2	300	23.45	23.45
03504	HYDROCHLOROTHIAZIDE		0	0		0.00	0.00	16	22	1,580	136.10	135.90
03507	TRICHLORMETHIAZIDE		5	10	640	52.25	52.20	81	106	8,034	648.85	646.60
03509	HYDROCHLOROTHIAZIDE/K		1	1	30	3.95	3.95	5	10	580	64.60	64.60
03512	CHLORTHALIDONE		3	3	84	11.80	11.80	69	106	3,939	497.45	497.45
03514	HYDROCHLOROTHIAZIDE&RESER		0	0		0.00	0.00	1	1	40	4.25	4.25
03800	PROBENECID		1	1	50	5.65	5.65	4	6	570	56.10	56.10
03950	POTASSIUM CHLORIDE		2	2	200	4.25	4.25	7	15	1,292	33.50	31.45
04300	ALUMINUM HYDROXIDE GEL		0	0		0.00	0.00	4	5	11	19.26	19.26
04302	AL&MG HYDROXIDE GEL		8	15	53	61.38	61.38	119	296	2,615	1,055.35	1,054.79
04306	CACO3&MGCO3 SUSPENSION		0	0		0.00	0.00	14	17	865	51.10	51.10
04800	BISMUTH NAGMA&PAREGORIC		3	3	128	5.50	5.50	28	31	240	58.25	58.25
05261	FERROUS GLUCONATE		0	0		0.00	0.00	8	9	960	21.60	11.62
05262	FERROUS SULFATE		3	3	320	5.80	4.65	11	11	1,041	19.45	17.05
05263	FERROUS FUMARATE		0	0		0.00	0.00	4	4	400	12.30	8.10

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05264	IMFERON		0	0		0.00	0.00	2	2	3	15.80	15.80
06210	NORETHYNODREL&MESTRANOL		2	4	24	11.80	9.55	5	8	28	24.20	18.40
06211	NORETHYNODREL&MESTRANOL		0	0		0.00	0.00	1	1	20	2.75	2.75
06215	NORETHINDRONE/MESTRANOL		4	5	161	22.55	20.15	95	162	1,002	799.58	739.30
06261	DIETHYLSTILBESTROL		1	1	12	1.30	1.30	2	2	24	2.60	2.60
06331	INSULIN		2	6	12	30.03	30.03	20	68	198	402.65	392.90
06350	CHLORPROPAMIDE TABLET		1	1	200	23.35	23.35	23	40	4,240	512.95	512.95
06351	PHENFORMIN	25MG	1	1	100	7.15	7.15	8	10	1,160	83.50	83.50
06352	TOLBUTAMIDE		3	4	400	42.10	39.80	43	92	10,700	1,098.80	1,051.35
06353	ACETOHEXAMIDE		0	0		0.00	0.00	1	1	100	9.95	9.95
06700	THYROID		2	4	400	7.60	7.60	16	32	3,200	63.20	63.10
06900	DIETHYLSTILBESTROL/MT	0.25-5MG	0	0		0.00	0.00	1	1	16	1.36	1.36
06904	CONJUGATED ESTROGENS/MT	0.625-5MG	2	2	150	19.70	19.70	12	14	1,830	114.15	109.60
06905	CONJUGATED ESTROGENS/MT	1.25-10MG	1	1	48	11.95	11.95	8	11	748	163.85	163.85
07070	NICOTINIC ACID		2	2	150	3.10	3.10	25	35	3,650	63.73	35.76
07075	PYRIDOXINE		0	0		0.00	0.00	13	17	1,560	78.11	54.18
07152	VITAMIN A,D,C/FLUORIDE	*	0	0		0.00	0.00	6	6	6	27.90	27.90
08002	CARBINOXAMINE MALEATE		5	5	208	12.95	12.95	74	84	3,259	210.75	209.75
08005	CHLORPHENIRAMINE MALEATE		2	3	116	7.65	7.65	66	80	3,371	224.40	224.35
08007	DEXTRO CHLORPHEN. MAL.		2	2	130	7.20	7.20	36	42	1,488	109.10	105.60
08008	DIPHENHYDRAMINE HCL		4	4	195	11.05	11.05	80	117	6,963	367.22	364.32
08009	DIPHENHYDRAMINE HCL/EPHED	.	2	2	8	3.80	3.80	3	3	12	5.55	5.55
08014	PROMETHAZINE		0	0		0.00	0.00	6	17	801	57.75	57.75
08015	DIPHENYLPYRALINE		0	0		0.00	0.00	1	1	50	2.95	2.95
08019	TRIPELENNAMINE		4	4	160	11.30	11.30	107	131	5,014	364.85	361.40
08020	TRIPELENNAMINE/EPHEDRINE		2	2	8	4.40	4.40	19	20	89	46.04	46.04
08941	PREDNISONE OTHER FORMS	*	0	0		0.00	0.00	2	2	40	3.45	3.45
08942	PREDNISOLONE TAB	* 1.0MG	0	0		0.00	0.00	2	2	40	3.40	3.40
08943	PREDNISOLONE TAB	* 2.5MG	0	0		0.00	0.00	1	1	24	1.80	1.80
08944	PREDNISOLONE TAB	* 5.0MG	0	0		0.00	0.00	3	3	60	4.80	4.75
08946	PREDNISONE TAB	* 2.5MG	0	0		0.00	0.00	2	2	40	3.40	3.40
08947	PREDNISONE TAB	* 5.0MG	21	24	660	45.40	44.95	245	328	10,289	658.90	658.25
09002	NEOMYCIN SULFATE	OPHT.OINT	0	0		0.00	0.00	1	1	2	10.75	10.75
09007	BACIT,NEOMYCIN,POLYMYXIN		0	0		0.00	0.00	1	1	1	2.80	2.80
09008	ICHQ & HYDROCORTISONE	*	1	1	20	5.85	5.85	55	65	232	453.55	451.00
09101	H.C. CREAM OR OINTMENT	1/4%	1	1	1	3.10	3.00	1	1	1	3.10	3.00
09102	H.C. CREAM OR OINTMENT	1%	1	1	1	3.10	3.00	19	24	150	98.85	98.55
09110	FLUOCINOLONE ACET.		2	2	2	11.30	11.15	47	50	318	279.70	278.05
09152	CALAMINE LOTION		0	0		0.00	0.00	3	3	12	3.65	2.28
09153	CALAMINE LOTION PHENOLATE	D	0	0		0.00	0.00	2	2	8	1.63	1.63
09161	CRUDE COAL TAR CR OR OINT		2	2	2	2.40	2.40	4	4	4	4.85	4.85
09162	CRUDE COAL TAR/ZNO OINT		0	0		0.00	0.00	3	3	5	4.00	4.00
09401	GRAMICIDIN,NEOMY,POLYMYX.		1	1	1	2.00	2.00	30	31	85	86.30	85.10
0955A	ACETYLCYSTEINE SOLN 10CC		1	1	30	8.30	8.30	1	1	30	8.30	8.30
09560	HYDROCORT./A.B.		0	0		0.00	0.00	2	2	13	8.45	8.45
09565	PREDNISOL/SOD SULFAC&DECO	.*	0	0		0.00	0.00	1	1	1	4.30	4.30
09600	POLYMYXIN B OTIC		0	0		0.00	0.00	1	1	1	2.50	2.50
09601	ANTIPYRINE & BENZOCAINE	OTIC	4	5	19	12.35	12.05	30	32	186	78.75	78.30
09800	OXYGEN	**	0	0		0.00	0.00	1	1	2	0.50	0.50
09802	SYRINGE/OR/OUT 2 NEEDLES	*	3	4	5	10.70	10.30	11	14	20	35.48	34.83

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09803	TWO HYPODERMIC NEEDLES *		1	10	20	7.41	7.20	14	38	76	26.48	26.17
09804	URINE-SUGAR TEST TAB AND-	PAPER*	2	2	101	4.03	4.03	23	32	1,814	68.09	67.94
09816	ELASTIC BANDAGE	*	0	0		0.00	0.00	4	4	5	8.19	8.19
09831	THERMOMETER ORAL-RECTAL		0	0		0.00	0.00	5	5	5	7.50	7.50
1007D	ISOPROTERENOL SOLN 10CC	1:200	4	9	54	32.70	32.70	8	14	78	50.50	50.50
1007F	ISOPROTERNOL SOLN 10CC	1:100	0	0		0.00	0.00	1	1	1	4.20	4.10
1007P	ISOPROTERENOL AEROSOL/ADA	15CC	3	11	172	68.50	68.50	8	30	357	186.60	186.60
1007R	ISOPROTERENOL AEROSOL/OUT	10CC	1	1	15	4.70	4.70	1	1	15	4.70	4.70
1010B	ISOPROTERENOL/PHENYLEPH.	22.5CC	2	2	46	12.65	12.65	7	10	54	61.65	61.20
1010D	ISOPROTERENOL/PHEN/OUT AD	22.5CC	3	5	116	36.70	36.70	5	8	142	58.00	58.00
1033D	PHENYLEPHRINE CAP	25MG	1	1	50	4.80	4.80	2	3	150	14.30	14.30
1102A	EPHEDRINE & AMOBARBITAL	CAPSULE	9	9	1,260	48.25	48.25	30	33	3,946	158.86	158.60
1173B	ISOXSUPRINE HCL TABLET	10MG	11	13	1,560	114.15	114.05	19	21	2,480	170.50	170.40
1200B	ERGONOVINE MALEATE TAB	0.2MG	1	1	24	3.10	3.10	10	10	162	28.70	28.70
1500F	PILOCARPINE OPH SOL 1%	15CC	1	1	15	3.40	3.40	1	1	15	3.40	3.40
1605B	BIPERIDEN TABLET	2MG	0	0		0.00	0.00	1	1	100	5.45	5.45
1606A	ORPHENADRINE HCL *	50MG	0	0		0.00	0.00	1	1	100	8.30	8.30
1608A	TRIHEXYPHENIDYL HCL TAB	2MG	1	1	200	5.30	5.30	4	5	700	22.00	22.00
1702B	BELLADONNA TINCTURE		0	0		0.00	0.00	1	1	1	2.45	2.45
1711D	METHSCOPOLAMINE BR/PB	DROPS	0	0		0.00	0.00	1	1	1	3.25	3.25
1712A	OXYPHENCYCLIMINE HCL	10MG	2	2	120	11.95	11.95	4	4	340	30.75	29.10
1717C	PROPANTHELINE BROMIDE TAB	15MG	7	8	870	52.35	52.30	17	19	2,080	125.05	124.95
1800A	BELLADONNA ALKALOIDS&BARB	TABLETS	13	13	1,400	47.60	47.25	47	49	5,210	177.80	177.45
1800B	BELLADONNA ALKALOIDS&BARB	LIQUID	14	16	3,376	56.35	56.30	53	75	6,817	261.22	259.97
1801A	BELL.ALK.ERGOT.TART&BARB.	TABLETS	7	7	900	54.20	54.00	10	10	1,200	73.40	73.20
1803A	BELL.ALK./BARB./ANTACID	TABLET	0	0		0.00	0.00	2	3	300	14.85	14.85
2036E	SOD SALICYLATE E.C. TAB	10GR	4	4	700	16.10	16.10	11	13	2,100	49.40	49.40
2037A	PHENAZOPYRIDINE HCL	0.1GM	1	1	120	8.50	8.50	3	4	390	29.20	29.20
2041A	INDOMETHACIN *	25MG	3	3	312	28.75	28.75	7	9	912	84.55	84.55
2041B	INDOMETHACIN *	50MG	0	0		0.00	0.00	1	1	100	13.50	13.50
2153E	BUTABARBITAL TAB OR CAP	1½GR	0	0		0.00	0.00	1	1	30	3.25	3.25
2155H	PENTOBARBITAL CAP	100MG	6	7	171	19.35	19.30	14	19	489	52.80	52.75
2156J	PHENOBARBITAL TAB	1/4GR	1	1	125	2.70	2.70	2	2	245	5.40	5.40
2156K	PHENOBARBITAL TAB	½GR	8	8	810	20.95	20.95	30	34	3,540	91.85	90.70
2160B	HEXOBARBITAL CAPSULES		0	0		0.00	0.00	1	1	30	3.65	3.60
2250B	CHLORAL HYDRATE CAPSULE	500MG	5	5	164	18.35	18.35	7	8	254	29.00	29.00
2251C	GLUTETHIMIDE	.5GM	0	0		0.00	0.00	2	2	60	7.00	7.00
2252C	METHYPRYLON CAP	300MG	4	4	120	16.15	16.15	14	18	540	71.65	71.55
2253B	METHAQUALONE CAP-TAB	200MG	17	18	540	63.05	63.05	48	55	1,650	192.60	192.55
2302A	COD.ASA.PHEN&CAFFEINE	1/8GR	0	0		0.00	0.00	2	2	48	5.50	5.40
2302B	COD.ASA.PHEN&CAFFEINE	1/4GR	64	65	2,104	201.05	201.00	294	398	13,176	1,224.40	1,215.63
2302C	COD.ASA.PHEN&CAFFEINE	½GR	14	15	395	50.57	50.57	75	98	2,351	319.14	316.89
2302D	COD.ASA.PHEN&CAFFEINE	1GR	2	3	44	10.30	10.30	2	3	44	10.30	10.30
2304K	MEPERIDINE HCL TABLET	50MG	0	0		0.00	0.00	14	16	348	52.15	48.40
2304M	MEPERIDINE HCL TABLET	100MG	7	8	168	30.00	30.00	16	22	516	88.40	84.40
2310E	CODEINE PO4 OR SO4 TAB	½GR	1	1	24	3.25	3.25	1	1	24	3.25	3.25
2407D	DIPHENYLHYDANTOIN CAP	50MG	0	0		0.00	0.00	2	2	200	6.10	6.10
2407E	DIPHENYLHYDANTOIN CAP	100MG	6	6	689	22.30	22.30	26	28	3,359	105.90	105.85
2502A	TERPIN HYDRATE&CODEINE		0	0		0.00	0.00	6	6	260	17.85	17.75
2503A	CHLORPHEN MAL.PHENYLEPH.	LIQUID	1	1	120	2.75	2.75	1	1	120	2.75	2.75

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2505A	DIPHENHYDRAMINE EXPECT.		25	25	4,800	78.45	78.35	132	140	9,436	418.40	418.00
2506A	PROMETHAZINE EXP PLAIN		0	0		0.00	0.00	3	3	128	8.75	8.75
2507A	PROMETHAZINE EXP/CODEINE		42	47	6,064	148.85	148.85	236	279	14,459	867.35	867.00
2510A	KI SAT. SOLN		24	25	676	63.75	63.75	144	151	2,092	386.40	386.20
2514A	PROMETHAZINE EXP VC/COD		0	0		0.00	0.00	1	1	2	2.35	2.35
2530A	TRIPELENNAMINE EXP/EPHED		0	0		0.00	0.00	15	16	192	49.65	49.65
2531A	TRIPELEN EXP/EPHED&COD.		3	3	360	9.45	9.45	42	43	2,088	135.65	135.20
2600E	CHLORPROMAZINE TABLET	25MG	7	7	710	56.80	56.80	24	26	2,890	224.29	223.79
2600H	CHLORPROMAZINE TABLET	100MG	0	0		0.00	0.00	1	1	100	10.80	10.80
2600K	CHLORPROMAZINE LIQUID	10MG/5CC	0	0		0.00	0.00	1	2	5	7.50	7.50
2600R	CHLORPROMAZINE SUSTAINED	150MG	1	1	100	18.90	18.90	5	5	487	92.05	88.85
2601C	PROCHLORPERAZINE TAB	5MG	5	5	348	32.55	32.55	28	33	2,392	221.45	220.45
2601D	PROCHLORPERAZINE TAB	10MG	0	0		0.00	0.00	2	2	160	17.15	17.15
2601E	PROCHLORPERAZINE TAB	25MG	0	0		0.00	0.00	3	3	86	15.80	15.80
2601P	PROCHLORPERAZINE SUPPOS	2.5MG	4	4	26	14.65	14.65	15	15	129	63.00	59.45
2601R	PROCHLORPERAZINE SUPPOS	5MG	0	0		0.00	0.00	1	1	24	3.75	3.75
2601S	PROCHLORPERAZINE SUPPOS	25MG	4	4	30	16.85	16.85	10	10	85	45.90	45.90
2603A	THIORIDAZINE TAB	10MG	0	0		0.00	0.00	1	1	100	10.80	10.80
2603B	THIORIDAZINE TAB	25MG	6	6	604	61.05	61.05	47	52	5,564	552.10	549.90
2603C	THIORIDAZINE TAB	50MG	8	8	568	67.25	67.25	23	24	2,184	237.60	237.45
2605B	CHLORPROTHIXENE TABLET	10MG	0	0		0.00	0.00	1	1	100	10.05	10.05
2608B	TRIFLUOPERAZINE TAB	1MG	0	0		0.00	0.00	1	1	100	8.30	8.30
2608E	TRIFLUOPERAZINE TAB	10MG	0	0		0.00	0.00	1	1	100	15.85	15.85
2611B	AMITRIPTYLINE&PERPHEN.	2-25	0	0		0.00	0.00	19	20	1,766	214.05	206.95
2612B	AMITRIPTYLINE TABLET	10MG	5	5	460	28.05	28.05	16	18	1,350	90.30	90.00
2612C	AMITRIPTYLINE TABLET	25MG	13	13	1,340	126.35	126.35	50	52	5,126	488.64	488.64
2615C	FLUPHENAZINE TAB	1MG	6	7	510	41.60	41.60	10	11	910	72.35	71.20
2625C	METHYLPHENIDATE TAB *	10MG	1	1	100	7.90	7.90	1	1	100	7.90	7.90
2644E	RESERPINE TAB	0.25MG	18	18	2,000	53.70	53.70	86	88	9,120	256.85	256.75
2903F	AMINOPHYLLINE SUPPOSITORY	0.5GM	2	2	36	8.75	8.75	9	13	230	55.35	55.35
2903M	AMINOPHYLLINE E.C.	3GR	1	1	50	2.75	2.75	1	1	50	2.75	2.75
2953A	THEOPHYLLINE,EPHED&PB	TAB	5	5	344	22.60	22.60	15	16	1,264	78.40	77.25
2953D	THEOPHYLLINE,EPHED&PB	LIQ	1	1	240	3.80	3.80	9	9	624	28.65	28.65
2953E	THEOPHYLLINE,EPHED&PB SUP	POS-CHILD	0	0		0.00	0.00	1	1	8	3.80	3.80
3000D	DIGITALIS TAB-CAP	100MG	0	0		0.00	0.00	2	3	200	8.90	8.90
3000E	DIGITALIS TINCTURE		0	0		0.00	0.00	1	1	100	1.90	1.90
3001E	DIGITOXIN. TABLET	0.1MG	0	0		0.00	0.00	1	2	130	5.75	5.75
3001H	DIGITOXIN. TABLET	0.2MG	0	0		0.00	0.00	2	2	120	6.20	6.20
3007B	DIGOXIN TABLET	0.25MG	1	1	50	2.85	2.85	7	7	600	23.72	22.95
3102D	QUINIDINE SULFATE TAB	200MG	2	2	200	12.60	12.60	9	9	960	63.90	59.45
3307B	METHYLDOPA TAB	250MG	0	0		0.00	0.00	3	4	520	40.40	40.40
3309B	PENTAERYTHRITOL TETRANIT.	20MG	2	2	240	13.80	13.80	11	13	1,456	85.30	84.70
3310B	PENTOLINIUM TARTRATE TAB	20MG	0	0		0.00	0.00	2	2	240	9.10	9.00
3311A	NITROGLYCERIN		4	4	180	9.95	9.95	13	19	1,066	47.75	47.70
3500D	ACETAZOLAMIDE CAPSULES	500MG	0	0		0.00	0.00	1	1	100	10.90	9.90
3504A	HYDROCHLOROTHIAZIDE	25MG	0	0		0.00	0.00	2	2	150	9.45	9.45
3504B	HYDROCHLOROTHIAZIDE	50MG	1	1	30	4.05	3.85	5	6	340	32.25	31.25
3507A	TRICHLORMETHIAZIDE TAB	2MG	1	1	100	5.95	5.95	3	3	280	17.40	17.40
3507B	TRICHLORMETHIAZIDE TAB	4MG	5	5	354	27.20	27.20	37	41	3,086	231.25	231.25
3509C	HYDROCHLOROTHIAZIDE/K	50-572	0	0		0.00	0.00	2	3	90	11.55	11.55

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DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
3509D	HYDROCHLOROTHIAZIDE/K	50-1000	0	0		0.00	0.00	1	1	100	8.50	8.50
3512A	CHLORTHALIDONE TABLET	50MG	0	0		0.00	0.00	3	4	254	21.40	21.40
3512B	CHLORTHALIDONE TABLET	100MG	5	5	202	29.90	29.90	27	30	892	133.20	133.20
3514A	HYDROCHLOROTHIAZIDE&RESER	"25"	0	0		0.00	0.00	1	1	40	4.50	4.50
3549B	FUROSEMIDE TAB	40MG	1	1	100	10.70	10.70	9	12	676	84.25	84.25
3550A	SPIRONOLACTONE	25MG	0	0		0.00	0.00	1	1	60	7.70	7.70
3600A	PROBENECID	500MG	1	1	100	7.70	7.70	3	3	240	20.70	19.85
3801A	PROBENECID/COLCHICINE		0	0		0.00	0.00	2	2	200	17.00	17.00
3950H	KCL E.C. TAB	5GR	2	2	200	6.30	6.30	5	5	500	15.75	15.75
4300D	ALUMINUM HYDROXIDE GELLIQ		1	1	720	3.40	3.40	2	2	722	6.80	6.80
4302C	AL&MG HYDROXIDE LIQUID		0	0		0.00	0.00	4	4	7	11.07	11.07
4303A	ALOH MGOH&SIMETHICONE TAB		1	1	100	2.00	2.00	5	6	404	15.90	15.89
4303B	ALOH MGOH&SIMETHICONE LIQ		30	36	25,881	146.18	146.18	88	129	29,028	494.60	494.53
4306A	CACO3&MGCO3 TABLET		4	5	500	10.79	10.79	14	15	1,206	39.02	38.69
5261A	FERROUS GLUCONATE TAB-CAP	5GR	1	1	100	8.70	3.20	4	4	400	18.00	12.50
5262A	FERROUS SULFATE TAB	200MG	1	1	120	3.50	3.50	2	2	220	6.80	6.80
5262D	FERROUS SULFATE E.C. TAB	325MG	2	2	180	6.40	6.40	3	3	300	9.90	9.90
5262H	FERROUS SULFATE LIQ		0	0		0.00	0.00	1	1	8	3.05	3.05
5263A	FERROUS FUMARATE TAB	3GR	0	0		0.00	0.00	2	2	220	8.55	8.55
5263B	FERROUS FUMARATE TAB	5GR	0	0		0.00	0.00	2	2	200	7.00	7.00
6211A	NORETHYNODREL&MESTRANOL	2.5MG	2	2	21	5.50	5.50	5	7	47	23.50	23.50
6211B	NORETHYNODREL&MESTRANOL	5MG	0	0		0.00	0.00	2	2	21	5.15	5.15
6215A	NORETHINDRONE/MESTRANOL	1MG	6	6	240	25.45	25.45	19	22	256	98.50	96.80
6215B	NORETHINDRONE/MESTRANOL	2MG	9	9	321	40.20	40.05	43	58	625	242.63	241.63
6217A	ETHYNODIOL DIAC&MESTRANOL		6	6	244	27.50	27.50	23	26	415	107.55	106.05
6220B	NORETHINDRONE/ETHIN-ESTRA	.2.5MG	0	0		0.00	0.00	1	1	60	6.20	6.20
6261E	DIETHYLSTILBESTROL TAB	5MG	0	0		0.00	0.00	1	1	12	2.60	2.40
6331A	INSULIN-NPH,PZ,LEN,GLOB	U40	3	4	130	18.25	18.25	9	20	208	95.01	93.78
6331B	INSULIN-NPH,PZ,LEN,GLOB	U80	2	2	60	14.17	14.17	7	11	82	82.48	76.54
6331D	INSULIN REGULAR U80		0	0		0.00	0.00	1	1	4	11.37	11.37
6350B	CHLORPROPAMIDE TABLET	250MG	6	7	700	68.69	68.69	23	30	2,960	289.24	287.14
6351A	PHENFORMIN	25MG	2	2	150	10.90	10.90	6	8	750	49.75	49.70
6352A	TOLBUTAMIDE	500MG	11	12	1,420	123.15	123.15	36	44	5,115	445.03	438.61
6700C	THYROID TAB PLAIN	1GR	6	6	660	17.35	17.35	11	12	1,340	34.60	34.50
6700D	THYROID TAB PLAIN	2GR	0	0		0.00	0.00	1	1	100	3.40	3.40
6810A	IOTHIOURACIL SODIUM	50MG	0	0		0.00	0.00	1	1	100	4.50	4.50
6904A	CONJUGATED ESTROGENS/MT *	1.25-10MG	2	2	160	17.70	17.70	6	6	360	41.65	41.60
6904B	CONJUGATED ESTROGENS/MT	1.25-10MG	3	3	150	28.50	28.50	7	7	400	73.85	73.10
7070B	NICOTINIC ACID	50MG	4	4	400	9.00	8.90	8	11	1,100	26.50	26.40
7075H	PYRIDOXINE TAB	50MG	4	5	400	16.75	16.75	8	10	800	33.45	33.45
7150C	VITAMIN A,D,C DROPS *	50CC	1	1	30	3.50	3.50	1	1	30	3.50	3.50
7152A	VITAMIN A,D,C/FLUORIDE *	100'S-TAB	1	1	100	4.50	4.50	1	1	100	4.50	4.50
7153A	VIT A,D,C&B6/FLUORIDE *	LIQ	1	1	30	3.80	3.80	1	1	30	3.80	3.80
8002A	CARBINOXAMINE MALEATE TAB	4MG	22	23	740	69.80	69.80	68	71	2,048	209.58	209.48
8005C	CHLORPHENIRAMINE MAL TAB	4MG	4	4	172	13.15	13.15	20	20	674	60.10	60.10
8005D	CHLORPHENIRAMINE MAL LIQ		0	0		0.00	0.00	2	2	124	5.70	5.70
8008D	DIPHENHYDRAMINE HCL CAP	25MG	2	2	130	6.55	6.55	4	4	254	12.95	12.95
8008E	DIPHENHYDRAMINE HCL CAP	50MG	11	11	790	42.70	42.70	36	37	2,890	146.45	146.45
8008F	DIPHENHYDRAMINE HCL LIQ	10MG/4CC	1	1	240	3.40	3.40	4	4	255	11.65	11.65
8009B	DIPHENHYDRAMINE HCL/EPHED	.LIQUID	0	0		0.00	0.00	1	1	4	3.30	3.30

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DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
8019B	TRIPELENNAMINE TAB	50MG	1	1	24	2.95	2.95	47	49	1,718	160.40	160.25
8103A	MECLIZINE HCL TABLET	25MG	2	2	160	14.45	14.45	4	6	360	35.85	35.85
8104A	TRIMETHOBENZAMIDE HCL	200MG	0	0		0.00	0.00	1	1	3	3.15	3.15
8110A	DICYCL.DOXYLAMINE,PYRID.*		1	1	30	4.90	4.90	1	1	30	4.90	4.90
8945C	PREDNISONE TAB	5MG	35	36	980	100.00	98.55	115	125	3,176	338.51	336.86
9003B	NEOMY.POLYMY,GRAMICIDIN	TOP.CR.	0	0		0.00	0.00	1	1	15	3.40	3.35
9015B	ERYTHROMYCIN TOP. OINT	1OZ	0	0		0.00	0.00	1	1	1	3.40	3.40
9020A	ZINC OXIDE PASTE		0	0		0.00	0.00	1	1	2	2.60	2.55
9101B	HYDROCORTISONE TOPICAL	½%	1	1	240	7.30	7.30	2	2	270	10.45	10.20
9110B	FLUOCINOLONE CR-OINT 0.01	60GM	6	6	360	31.80	31.80	29	29	973	153.70	153.70
9110C	FLUOCINOLONE CR-OINT 0.01	OTHERQUANT	0	0		0.00	0.00	1	1	1	5.30	5.30
9110E	FLUOCINOLONE ACET.SOLN	60CC	1	1	60	6.50	6.50	2	3	62	19.50	19.50
9124E	H.C./IODOCHLORHYDROXYQUIN	½%-1OZ	0	0		0.00	0.00	1	1	28	4.90	4.90
9124J	H.C./IODOCHLORHYDROXYQUIN	1%-20GM	6	6	120	32.95	32.95	22	22	196	129.65	129.55
9153A	CALAMINE LOTION PHENOLATE	D	0	0		0.00	0.00	2	2	124	5.15	5.15
9162A	CRUDE COAL TAR/ZNO OINT		1	1	142	3.60	3.60	1	1	142	3.60	3.60
9401A	NEOMY.POLYMY,GRAMICIDIN	OPHT.SOLN.	1	1	10	3.40	3.40	13	14	68	47.15	46.95
9402B	SULFISOXAZOLE OPHT SOLN	15CC	2	2	30	6.55	6.55	2	2	30	6.55	6.55
9419A	NEOMY.BACIT.POLYMYXIN	OPHT.OINT.	1	1	4	2.80	2.80	1	1	4	2.80	2.80
9502A	NYSTATIN VAG TAB		0	0		0.00	0.00	1	1	30	5.05	5.05
9504A	NITROFURAZONE VAG SUPPOS		0	0		0.00	0.00	1	1	24	5.90	5.90
9508A	CHLORDANTOIN VAG CR/APPL.		9	10	950	52.15	52.15	30	33	1,913	173.58	172.58
9509B	SULTRIN TUBE/APPLICATOR		0	0		0.00	0.00	1	1	1	4.90	4.90
9512A	FURAZOLIDONE&NIFUROXIME		1	1	24	5.30	5.30	18	18	271	95.00	94.40
9564C	PREDNISOL/SULF/OR/OUT DEC	*1/4%-5CC	0	0		0.00	0.00	1	1	1	4.40	4.40
9564E	PREDNISOL/SULF/OR/OUT DEC	*½%-5CC	2	2	10	8.80	8.80	2	2	10	8.80	8.80
9601A	ANTIPYRINE & BENZOCAINE	OTIC	6	6	90	19.30	19.30	18	18	200	57.45	57.45
9611A	POLYMYXIN B OTIC	10CC	1	1	10	3.30	3.30	2	2	11	6.60	6.60
9802A	SYRINGE ONLY-INSULIN		2	2	2	6.61	6.61	2	2	2	6.61	6.61
9802C	SYRINGE/2 NEEDLES-INSULIN		2	2	2	8.95	7.45	2	2	2	8.95	7.45
9803A	HYPODERMIC NEEDLES		3	3	6	1.97	1.96	10	17	35	12.19	11.76
9804B	CLINITEST TAB	36'S	0	0		0.00	0.00	1	1	36	0.90	0.90
9804C	CLINITEST TAB	100'S	1	1	100	2.05	2.05	5	6	600	12.30	12.30
9804E	CLINITEST SET		0	0		0.00	0.00	1	1	1	1.98	1.98
9804F	TESTAPE	100'S	2	2	2	4.00	4.00	4	5	5	10.24	10.24
9816D	ELASTIC BANDAGE	3INCHES	1	1	1	1.95	1.75	1	1	1	1.95	1.75
9831A	THERMOMETER		1	1	1	1.25	1.25	5	5	5	6.75	6.50
9843A	VAPORIZER		2	2	2	14.60	14.60	4	4	4	28.85	28.85

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DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
		CURRENT TOTALS				YEAR TO DATE TOTALS						
NO. OF PRESCRIPTIONS		1,384				11,051						
AMOUNT BILLED		5,735.22				45,398.12						
AMOUNT PAID		5,694.00				44,900.09						
AMOUNT OF ADJUST		41.22				498.03						
COUNT OF FEE ADJUST		84				1,005						
AMOUNT OF FEE ADJUST		41.22				498.03						
COUNT OF QTY ADJUST												
AMOUNT OF QTY ADJUST												
COUNT OF $50 PRESC.												
AMOUNT OF $50 PRESC.												
AVERAGE COST PER PRESC		4.11				4.06						

This physician's prescriptions were half again as much as his professional fees (see previous report). Upon further analysis it was discovered that almost 90% of these prescriptions were filled at one pharmacy. Further review of these statistics is merited in this case.

DRUG CODE	DESCRIPTION	STRENGTH	CURRENT # OF CASES	CURRENT # OF PRESC	CURRENT QUANT	CURRENT AMOUNT BILLED	CURRENT AMOUNT PAID	YEAR TO DATE # OF CASES	YEAR TO DATE # OF PRESC	YEAR TO DATE QUANTITY	YEAR TO DATE AMOUNT BILLED	YEAR TO DATE AMOUNT PAID
0242C	OXYTETRACYCLINE I.M.	250MG	1	1	6	8.80	8.80	2	2	8	12.80	12.80
0242E	OXYTETRACYCLINE I.V.	500MG	0	0		0.00	0.00	2	2	6	17.55	16.85
0244A	TETRACYCLINE INJ	100MG	1	1	16	3.05	3.05	21	23	362	103.15	99.70
0244B	TETRACYCLINE INJ	250MG	1	1	12	1.70	1.70	11	11	173	43.33	40.95
0244C	TETRACYCLINE INJ	500MG	1	2	6	16.80	16.80	1	2	6	16.80	16.80
0244D	TETRACYCLINE TAB-CAP	50MG	0	0		0.00	0.00	4	9	178	26.60	26.60
0244E	TETRACYCLINE TAB-CAP	100MG	1	1	16	3.28	3.25	21	24	354	76.93	76.65
0244F	TETRACYCLINE TAB-CAP	125MG	4	4	54	14.05	13.85	16	16	234	57.27	55.47
0244H	TETRACYCLINE TAB-CAP	250MG	820	976	18,629	3,011.92	3,003.22	3869	4994	90,295	15,266.68	15,169.15
0244K	TETRACYCLINE LIQ	125MG/5CC	184	219	15,443	667.89	662.85	845	978	38,271	2,994.47	2,940.21
0244M	TETRACYCLINE DROPS	100MG/CC	14	14	140	44.49	44.29	90	100	1,077	314.98	313.78
0244N	TETRACYCLINE TROCHES		0	0		0.00	0.00	2	2	26	5.60	5.60
0244P	TETRACYCLINE PHARYNGETS		1	1	16	3.30	3.30	3	4	116	13.30	13.30
02502	TERPIN HYDRATE&CODEINE		66	104	1,916	207.65	206.05	440	641	16,489	1,330.81	1,314.52
02503	CHLORPHEN MAL COMPOUND		79	98	1,747	224.13	222.23	534	662	16,069	1,381.52	1,382.53
02505	BENYLIN EXPECTORANT		108	133	2,421	270.35	268.65	778	1004	21,798	2,136.28	2,124.93
02506	PHENERGAN EXP. PLAIN		108	135	2,471	273.73	272.78	829	1129	25,533	2,379.00	2,350.65
02507	PHENERGAN EXP/CODEINE		237	329	6,360	749.93	744.93	1833	2928	53,479	7,010.80	6,941.47
02508	PHENERGAN EXP PEDIATRIC		43	53	812	121.30	120.60	257	297	3,149	674.64	667.62
02509	CHERACOL LIQUID		36	40	612	114.40	113.70	330	389	5,024	1,050.68	1,032.23
02510	KI SAT. SOLN		46	52	610	94.66	88.81	493	725	9,391	1,290.42	1,246.06
02512	TOCLONOL		2	4	30	14.00	11.85	24	34	531	84.50	74.77
02513	PHENERGAN EXP. VC PLAIN		57	72	2,895	148.21	147.36	327	425	12,197	915.53	902.62
02514	PHENERGAN EXP VC/CODEINE		164	208	4,171	449.13	448.03	969	1228	22,347	2,754.00	2,731.48
02517	CEROSE		2	2	10	5.15	5.15	15	15	387	40.45	39.75
02518	CEROSE DM		0	0		0.00	0.00	5	18	72	28.62	28.34
02530	T.IPELENNAMINE EXP/EPHED		27	35	461	77.50	77.50	239	278	7,943	621.23	617.08
02531	TRIPELEN EXP/EPHED&COD.		13	13	179	37.55	36.30	162	259	5,207	698.53	695.15
0253A	TRIACETYLOLEANDOMYCIN CAP	125MG	0	0		0.00	0.00	1	1	12	3.75	3.75
0253B	TRIACETYLOLEANDOMYCIN CAP	250MG	37	42	674	242.15	241.90	91	108	1,756	631.86	626.07
0253C	TRIACETYLOLEANDOMYCIN LIQ	125MG/CC	3	4	360	19.50	19.00	14	16	605	77.95	71.90
02552	CORYBAN D		3	3	128	5.08	4.47	42	76	2,428	159.46	149.35
02600	CHLORPROMAZINE TAB&SPAN.		97	213	11,121	1,859.80	1,825.00	1368	3689	188,730	28,622.55	28,085.43
02601	PROCHLORPERAZINE		102	132	4,194	762.90	756.55	1060	1836	58,197	11,000.67	10,928.48
02602	IMPRAMINE HYDRACLORIDE		19	31	3,368	404.35	402.10	276	566	48,456	5,918.58	5,895.98
02603	MELLARIL		100	183	13,973	2,050.70	2,037.60	1367	3083	220,460	31,096.46	30,916.42
02608	STELAZINE		98	170	10,534	1,662.52	1,653.17	856	1627	97,839	14,866.15	14,763.12
02609	TRILAFON		19	44	2,429	283.95	278.40	190	481	28,108	3,534.98	3,495.85
02612	ELAVIL		66	126	11,130	1,333.10	1,324.50	670	1315	109,916	12,973.90	12,825.79
02615	FLUPHENAZINE	*	26	44	3,158	433.60	419.75	284	517	34,614	4,161.45	4,097.00
0262F	CHLORAMPHENICOL CAPSULES	250MG	3	7	178	48.85	48.85	12	16	382	110.45	107.40
0262H	CHLORAMPHENICOL LIQUID	60CC	0	0		0.00	0.00	2	2	120	9.70	9.70
02641	RAUWOLFIA SERPENTINA	50MG	5	7	570	12.45	10.20	52	104	8,465	184.30	180.95
02642	RAUWOLFIA SERPENTINA	OTHERFORM	0	0		0.00	0.00	10	10	752	100.90	100.70
02643	RAUWOLFIA SERPENTINA	10MG	5	5	460	9.60	9.60	76	146	14,860	315.26	310.01
02644	RESERPINE OTHER FORMS		2	3	600	13.55	13.55	25	32	4,280	100.25	100.25
02645	RESERPINE TAB	0.1MG	16	21	1,680	38.20	37.75	301	535	39,459	929.98	924.98
02646	RESERPINE TAB	0.25MG	95	130	10,307	239.20	226.40	1518	2865	222,839	5,073.08	4,989.08
02647	RESERPINE TAB	0.5MG	0	0		0.00	0.00	17	20	1,412	38.20	37.25
02648	RESERPINE TAB	1.0MG	0	0		0.00	0.00	10	11	660	27.61	26.41

CBS NO. HC0000560 PROVIDER NAME PROVIDER NO. 056 PROVIDER CODE 50

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV FEE REJ COM UT
2-B0001		1 BED ROOM	10	1,258.30	.60	.03	755.00	715.00	40.00		
2-B0002		2-3-4 BED ROOM	835	176,361.82	.36	.02	63,617.50	60,937.50	2,680.00		
2-B0003		5 OR MORE BEDS	65	31,444.80	.16		4,900.50	4,860.50	40.00		
2-B0010		BLOOD BANK CHARGE	17	108.33	1.57	1.20	170.00	40.00	130.00		
2-B0014		BILLED NOT PAID	1								
2-B0020		1-BED ROOM	43	7,795.08	.45	.02	3,540.50	3,370.50	170.00		
2-B0021		2-3-4 BED ROOM	4219	847,213.96	.39	.08	326,519.14	260,213.10	66,306.04		
2-B0022		5 OR MORE BEDS	38	4,189.08	.74	.03	3,087.50	2,967.50	120.00		
2-B0038		OTHER "MISC"	7	254.00	6.00	.38	1,524.00	1,428.00	96.00		
2-B0039		BLOOD	101	543.37	1.34	1.38	730.00	460.00	750.00		
2-B0047		CLINIC VISIT	1323	5,499.44	3.92	2.15	21,557.58	9,751.31	11,806.27		
2-B0048		EMERGENCY ROOM	254	1,735.22	4.69	3.19	8,142.00	2,612.20	5,529.80		

TOTAL UNITS BILLED	1,076,403.40	TOTAL ITEMS OVERUTIL	COMM
AVERAGE BILLED UNIT COST	.40	TOTAL ITEMS FEE	COMM
AVERAGE PAID UNIT COST	.08	TOTAL ITEMS REJECT	COMM
TOTAL AMOUNT BILLED	434,543.72	TOTAL PAID BY OTHER INS	310.00
TOTAL PAID OTHER	347,355.61	TOTAL PAID BY PATIENT	59.60
TOTAL PAID BY MEDI-CAL	87,668.11	TOTAL NOT PAID	55.00
TOTAL ADJUST AMOUNT		TOTAL PAID BY MEDICARE	346,986.01
TOTAL OVERUTIL ADJUST		TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST		TOTAL FEE ADJUST COMM	
TOTAL REJECTS		TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ		TOTAL TARS DISAPPROVED	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 546

CBS NO. 0000E5740 PROVIDER NAME — PROVIDER NO. 0E574 — PROVIDER CODE 32

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV FEE REJ COM UT
4-01711		FOOT APPLIANCE	30	480.00	.89	.89	427.50		427.50		
4-01799		UNLISTED APP OR PRO	2	10.00	3.00	3.00	30.00		30.00		
4-03004		PODIATRY-ROUTINE-OFFICE	975	4,875.00	1.04	1.00	5,057.00		4,877.00	180.00	
4-03005		PODIATRY-NOT ROUT-OFFICE	92	644.00	1.01	.99	650.00		635.00	15.00	
4-03014		PODIATRY-ROUTINE-NURSE,HM	59	413.00	.99	.99	409.00		407.00	2.00	
4-03015		PODIATRY-NOT ROUT-NRSE,HM	21	168.00	1.04	.99	175.00		167.00	8.00	
4-03018		PODIATRY-ADD PAT SAME RES	534	2,670.00	1.08	.94	2,896.00		2,497.00	399.00	
4-03079		UNLISTED ITEM ACOUSTICON	1	1.33	6.02	6.02	8.00		8.00		
4-03225		AVULSION NAIL	6	294.50	.22	.20	65.00		60.00	5.00	
4-03228		EXCISION OF NAIL	7	175.00	.93	.93	162.50		162.50		
4-03232		NAIL DEBRIDEMENT TO 5	3	30.00	.90	.90	27.00		27.00		
4-03370		FX METATARSA OPEN RED	1	125.00	.15	.15	19.24		18.75	.49	
4-03370	50%	FX METATARSA OPEN RED	1	62.50	.15	.15	9.38		9.38		
4-03809		X-RAY FOOT TWO PROJ	32	256.00	1.06	1.01	271.00		258.00	13.00	
4-03810		X-RAY FOOT COMPLETE	8	80.00	.88	.88	70.00		70.00		

TOTAL UNITS BILLED	10,284.33	TOTAL ITEMS OVERUTIL	COMM
AVERAGE BILLED UNIT COST	1.00	TOTAL ITEMS FEE	COMM
AVERAGE PAID UNIT COST	.94	TOTAL ITEMS REJECT	COMM
TOTAL AMOUNT BILLED	10,276.62	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	9,654.13	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	622.49	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST		TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST		TOTAL FEE ADJUST COMM	
TOTAL REJECTS		TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ	622.49	TOTAL TARS DISAPPROVED	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 530

CBS NO. DC0095320 PROVIDER NAME — PROVIDER NO. 09532 — PROVIDER CODE 30

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV UT	FEE	REJ	COM
4-00201		ROUTINE OV	534	2,136.00	1.00	.97	2,136.00		2,076.00	60.00	15			
4-00202		OV HIST, EXAM, TREATMENT	82	574.00	.98	.98	565.00		565.00					
4-00221		SPINE CERVICAL	5	50.00	1.00	1.00	50.00		50.00					
4-00224		SPINE CERVICAL OB & FLEX	27	540.00	1.00	1.00	540.00		540.00					
4-00226		SPINE LUMBOSACRAL	2	20.00	1.00	1.00	20.00		20.00					
4-00232		SPINE THORACIC	32	320.00	1.00	.88	320.00		280.00	40.00	2	2	1	
4-00235		PELVIS	26	260.00	1.00	.88	260.00		230.00	30.00	2	2		
4-00236		PELVIS WITH LATERAL	7	98.00	.96	.86	94.00		84.00	10.00			1	
4-00239		FULL SPINE	2	44.00	1.00	1.00	44.00		44.00					
4-00243		SHOULDER	1	6.00	1.00	1.00	6.00		6.00					
4-00251		HAND & WRIST	1	6.00	1.00	1.00	6.00		6.00					
4-00261		HIP	1	6.00	1.00	1.00	6.00		6.00					
4-00263		KNEE	7	42.00	1.00	.86	42.00		36.00	6.00	1			
4-00269		FOOT & ANKLE	1	6.00	1.00	1.00	6.00		6.00					

TOTAL UNITS BILLED	4,108.00	TOTAL ITEMS OVERUTIL	20 COMM
AVERAGE BILLED UNIT COST	1.00	TOTAL ITEMS FEE	4 COMM
AVERAGE PAID UNIT COST	.96	TOTAL ITEMS REJECT	2 COMM
TOTAL AMOUNT BILLED	4,095.00	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	3,949.00	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	146.00	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST	106.00	TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST	20.00	TOTAL FEE ADJUST COMM	
TOTAL REJECTS	20.00	TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ		TOTAL TARS DISAPPROVED	

CBS NO. SD0021915 PROVIDER NAME PROVIDER NO. 52191 PROVIDER CODE 28

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV FEE REJ COM UT
4-00701		VIS ANALYSIS	1295	22,662.50	.81	.80	18,267.60		18,102.60	165.00	
4-00702		VIS ANALYSIS	1	10.00	1.50	1.50	15.00		15.00		
4-02001		SIN VIS 0.00-7.00 DI	700	1,918.37	2.09	2.09	4,007.13		4,007.13		
4-02002		SIN VIS 7.25-20.00 DI	3	16.66	1.86	1.86	30.93		30.93		
4-02005		BIFOCAL 0.00-7.00 DI	739	3,740.89	2.20	2.20	8,218.98		8,218.98		
4-02006		BIFOCAL 7.25-20.00 DI	13	171.73	.56	.56	96.38		96.38		
4-02007		BIFOCAL LENTICULAR	1	27.50	1.00	1.00	27.50		27.50		
4-02009		TRIFOCAL 0.00-7.00 DIOPTS	6	90.00	1.00	1.00	90.00		90.00		
4-02011		SIN VIS 0.00-5.00 DI	2	4.66	3.00	3.00	14.00		14.00		
4-02012		SIN VIS 5.25-10.00 DI	2	2.55	6.00	6.00	15.30		15.30		
4-02013		SIN VIS 10.25-12.00 DI	6	14.56	3.00	3.00	43.70		43.70		
4-02014		SIN VIS 12.25-16.00 DI	2	30.00	1.00	1.00	30.00		30.00		
4-02016		BIFOCAL 0.00-5.00 DI	2	30.00	1.07	1.07	32.00		32.00		
4-02017		BIFOCAL 5.25-10.00 DI	7	51.94	2.58	2.58	133.83		133.83		
4-02018		BIFOCAL 10.25-12.00	9	88.63	2.67	2.67	236.68		236.68		
4-02019		BIFOCAL 12.25-16.00	1	4.50	6.00	6.00	27.00		27.00		
4-02031		BALANCE 50% OF ALLOWANCE	25	18.11	5.36	5.36	97.00		97.00		
4-02041		FRAMES	676	6,760.00	1.00	1.00	6,747.50		6,747.50		
4-02044		REPAIRS AD PADS (EACH)	2	3.00	1.00	1.00	3.00		3.00		
4-02045		REPAIRS FRONT	27	162.00	.95	.95	154.00		154.00		
4-02046		REPAIRS TEMPLES (EACH)	116	232.00	1.05	1.05	244.00		244.00		
4-02047		REPAIRS HINGES (EACH)	3	1.50	6.33	6.33	9.50		9.50		
4-02066		ARMOR PLATE	1456	2,184.00	1.00	1.00	2,186.50		2,183.50		
4-02071		PRISM SIN OR BIFOCAL	41	82.00	1.07	1.07	88.00		88.00		
4-02073		PRISM SIN TINTED	21	21.00	1.10	1.10	23.00		23.00		
4-02074		PRISM BIFOCAL TINTED	57	85.50	1.01	1.01	86.50		86.50		
4-02081		UNLISTED ITEM	17	8.42	4.57	4.57	38.45		38.45		

TOTAL UNITS BILLED	38,422.02	TOTAL ITEMS OVERUTIL	COMM
AVERAGE BILLED UNIT COST	1.07	TOTAL ITEMS FEE	COMM
AVERAGE PAID UNIT COST	1.06	TOTAL ITEMS REJECT	COMM
TOTAL AMOUNT BILLED	40,963.48	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	40,795.48	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	165.00	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST		TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST		TOTAL FEE ADJUST COMM	
TOTAL REJECTS		TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ	165.00	TOTAL TARS DISAPPROVED	

PROVIDER PROCEDURE ANALYSIS PROFILE — OVERALL YEAR-TO-DATE — DATE 04/02/69 — PAGE NO. 612

CBS NO. ZZZ30017Z — PROVIDER NAME — PROVIDER NO. Z30017 — PROVIDER CODE 43

PROC CODES	PCT	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	OV UT	FEE	REJ	COM
4-07806		T-4	2	6.00	2.50	2.50	15.00		15.00					
4-08458		OTHER CULTURE DEFINITIVE	25	187.50	1.01	1.00	190.00		187.50	2.50				
4-08459		CULTURE/SENSITIVITY TESTS	3	37.50	.96	.83	36.00		31.00	5.00				
4-08475		SMEAR FOR ORGANISMS	3	21.00	.49	.43	10.20		9.00	1.20				
4-08477		SMEAR UNSTAINED WET MOUNT	2	8.00	.83	.75	6.60		6.00	.60				
4-08555		MISCELLANEOUS	2	2.50	6.00	6.00	15.00		15.00					
4-08606		ANTISTREPTOLYSIN TITER	2	12.00	1.25	1.00	15.00		12.00	3.00				
4-08610		BASOPHILIC AGGREGATES	1	7.50	1.00	1.00	7.50		7.50					
4-08611		BILIRUBIN	1	5.00	1.20	1.00	6.00		5.00	1.00				
4-08612		BLEEDING TIME	1	2.00	1.20	1.00	2.40		2.00	.40				
4-08622		BLOOD HEMOGLOBIN DETERMIN	82	164.00	1.15	1.02	188.80		167.20	21.60				
4-08624		BLOOD WHITE CELL COUNT	70	140.00	1.14	1.02	159.60		143.20	16.40				
4-08626		BLOOD DIFFERENTIAL COUNT	69	138.00	1.14	1.02	157.60		141.20	16.40				
4-08628		BLOOD COMPLETE COUNT	23	138.00	.97	.97	134.00		134.00					
4-08646		CEPHALIN FLOCCULATION	2	10.00	1.10	1.00	11.00		10.00	1.00				
4-08652		CHOLESTEROL	3	15.00	1.20	1.00	18.00		15.00	3.00				
4-08659		COAGULATION TIME	1	2.00	1.20	1.00	2.40		2.00	.40				
4-08661		COMPLEMENT FIXATION TESTS	15	75.00	1.00	1.00	75.00		75.00					
4-08666		CREATINE	1	5.00	1.20	1.00	6.00		5.00	1.00				
4-08681		HEMATOCRIT	7	14.00	1.17	1.00	16.40		14.00	2.40				
4-08692		LATEX IMMOBILIZATION	4	12.00	1.50	1.00	18.00		12.00	6.00				
4-08710		PROTEIN-BOUND IODINE	3	15.00	1.50	1.00	22.50		15.00	7.50				
4-08712		PROTHROMBIN TIME	1	3.50	1.43	1.00	5.00		3.50	1.50				
4-08715		RETICULOCYTE COUNT	1	3.00	1.67	1.00	5.00		3.00	2.00				
4-08716		RH TITER	1	5.00	1.20	1.00	6.00		5.00	1.00				
4-08718		SEDIMENTATION RATE	7	21.00	1.29	1.00	27.00		21.00	6.00				
4-08722		SUGAR	3	15.00	1.20	1.00	18.00		15.00	3.00				
4-08723		SUGAR 3 HRS	4	60.00	1.20	1.00	72.00		60.00	12.00		1		
4-08739		BLOOD TYPING ABO & RH	15	120.00	.94	.94	113.00		112.50	.50				
4-08740		BLOOD TYPING RH FACTOR	1	3.00	2.50	1.00	7.50		3.00	4.50				
4-08741		BLOOD TYPING COOMBS	1	5.00	1.00	1.00	5.00		5.00					
4-08745		UREA NITROGEN	2	6.00	2.00	1.67	12.00		10.00	2.00				
4-08747		URIC ACID	2	10.00	1.20	1.00	12.00		10.00	2.00				
4-08861		SPINAL ROUTINE MICRO	1	2.00	1.20	1.00	2.40		2.00	.40				
4-08932		BILE PIGMENTS	1	1.50	2.00	1.00	3.00		1.50	1.50				
4-08936		URINE COMPLETE ROUTINE	80	200.00	1.17	1.01	234.50		201.00	33.50				
4-08956		URINE ROUTINE MICROSCOPIC	4	6.00	1.33	1.05	8.00		6.30	1.70				
4-09101		ELECTROCARDIOGRAM	1	3.00	5.00	5.00	15.00		15.00					

TOTAL UNITS BILLED	1,481.00	TOTAL ITEMS OVERUTIL	COMM
AVERAGE BILLED UNIT COST	1.12	TOTAL ITEMS FEE	1 COMM
AVERAGE PAID UNIT COST	1.01	TOTAL ITEMS REJECT	COMM
TOTAL AMOUNT BILLED	1,658.40	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	1,497.40	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	161.00	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST		TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST	3.00	TOTAL FEE ADJUST COMM	
TOTAL REJECTS		TOTAL REJECTS COMM	

CBS NO. ZZZ320562 PROVIDER NAME PROVIDER NO. Z32056 PROVIDER CODE 40

PROC CODES	PCI	DESCRIPTION	FREQ	UNITS BILLED	BILL UNIT COST	PAID UNIT COST	BILLED AMOUNT	PAID OTHER	PAID MED-CAL	AMOUNT ADJUST	CV FEE REJ COM UT
4-03002		SILHOUETTE EAR MOLD	31	372.00	1.04	1.01	387.08		374.48	12.60	
4-03065		A670 ACOUSTICON B-T-E	1	234.50	1.05	1.05	246.96		246.96		
4-03066		A675 ACOUSTICON B-T-E	1	234.50	1.05	.95	246.96		222.29		
4-03067		A940 ACOUSTICON EYEGLASS	1	227.50	.99	.99	225.42		225.42		
4-03079		UNLISTED ITEM ACOUSTICON	145	3,133.87	.06	.06	173.90		173.90		
4-03271		DS1284 DAHLBERG I-T-E	7	1,571.50	.40	.37	629.76		574.76	55.00	
4-03274		CZ1206 DAHLBERG B-T-E	4	874.00	.60	.60	521.76		521.76		
4-03275		DC1207 DAHLBERG B-T-E	2	449.00	1.02	1.02	460.06		460.06		
4-03279		UNLISTED ITEMS DAHLBERG	39	34.97	5.99	5.99	209.53		209.53		
4-03301		INT 50 ECON FIDEL B-T-E	1	198.95	1.05	1.05	209.63		209.63		
4-03579		UNLISTED ITEMS OTARION	2	7.72	6.00	6.00	46.30		46.30		
4-03603		SUPER SUPREME X QUALITONE	3	637.50	.85	.85	544.51		544.51		
4-03604		HIDDEN EAR II S.D.W.D.	1	207.50	1.05	1.05	218.61		218.61		
4-03605		POWER HIDDEN EAR QUAL	1	214.50	1.05	1.05	225.96		225.96		
4-03606		FRONT MIKE SUPER QUAL	6	1,245.00	.77	.72	953.82		895.44	52.60	
4-03639		UNLISTED ITEMS QUALITONE	17	32.09	6.00	6.00	192.62		192.62		
4-03647		FRONTAL MINI AVC REXTON	1	200.00	1.15	1.00	229.50		200.00	29.50	

TOTAL UNITS BILLED	9,875.10	TOTAL ITEMS OVERUTIL	COMM
AVERAGE BILLED UNIT COST	.58	TOTAL ITEMS FEE	COMM
AVERAGE PAID UNIT COST	.56	TOTAL ITEMS REJECT	COMM
TOTAL AMOUNT BILLED	5,722.38	TOTAL PAID BY OTHER INS	
TOTAL PAID OTHER		TOTAL PAID BY PATIENT	
TOTAL PAID BY MEDI-CAL	5,542.23	TOTAL NOT PAID	
TOTAL ADJUST AMOUNT	149.70	TOTAL PAID BY MEDICARE	
TOTAL OVERUTIL ADJUST		TOTAL OVERUTIL ADJ COMM	
TOTAL FEE ADJUST		TOTAL FEE ADJUST COMM	
TOTAL REJECTS		TOTAL REJECTS COMM	
TOTAL REVIEW DESK ADJ	29.50	TOTAL TARS DISAPPROVED	120.20

PHYSICIANS' PRACTICE ANALYSIS PROFILE

Grand Totals, Overall Year-To-Date

Total Units Billed	256,592.30	Total Items Overutil	357	COMM	39
Average Billed Unit Cost	5.61	Total Items Fee	3,538	COMM	96
Average Paid Unit Cost	5.25	Total Items Reject	1,923	COMM	211
Total Amount Billed	1,438,201.45	Total Paid By Other Ins	8,502.58		
Total Paid Other	8,502.58	Total Paid By Patient			
Total Paid By Medi-Cal	1,339,825.78	Total Not Paid			
Total Adjust Amount	90,187.49	Total Paid By Medicare			
Total Overutil Adjust	1,499.00 (a)	Total Overutil Adj Comm	121.50		
Total Fee Adjust	21,410.15	Total Fee Adjust Comm	845.55		
Total Rejects	13,273.35 (a)	Total Rejects Comm	1,138.15		
Total Review Desk Adj	51,899.79 (b)	Total Tars Disapproved			

(a)—These items represent overutilization adjustments.
(b)—This item is a combination of fee adjustment and overutilization adjustment.

SOME COMMENTS ON DRUG UTILIZATION

By Vic Boisseree
Office of Health Care Services
State of California

The amount of drug utilization in this four-county area has been somewhat a revelation to the prescriber and the Medical Foundation itself.

I don't believe we realize the extent of drug use by our society today. It is demonstrated through these profiles that the pharmacy profession is dispensing on doctors orders a large number of drugs to patients and probably in excess to the actual need of particular patients; e.g., a physician may establish an order for a particular drug at some point in time for whatever purpose. He forgets that the patient is on the drug and at some future time will prescribe another one.

We are able through this profile system of relating on-going patterns to accurate record keeping to demonstrate a need for closer liaison between the provider, the pharmacy and the prescribing physician. We have been able to demonstrate through the use of patient profiles a large number of prescriptions which, when queried to the prescriber, turn out to be that the prescriber has no record of ever having authorized these.

What we are seeing here is some abuse within the pharmacy profession of potential control which has been placed upon them by pharmacy regulation. We have gone back to the provider, identified the problem to them and tightened up in a number of areas where there has been some loose control.

We have in the San Joaquin Foundation, as you may be aware, utilized pharmacy students from the University of Pacific to do some of the screening to interpret some of the totally unintelligible writing of both the pharmacists and the physicians. I think this is something that is unique to the Foundation project yet is a very easily mastered problem statewide if we change our billing statement to allow a typewritten document.

I don't believe that anyone other than the pharmacist can read either a pharmacist or physician's writing today. I would say that the big advantage of the pharmacy's involvement with the local providers has been to educate them to the problems of the program.

	Current Totals	Year To Date Totals
No. of Prescription	103,386	252,812
Amount Billed	409,175.95	993,156.68
Amount Paid	404,075.33	979,345.21
Amount of Adjust	5,074.77	13,742.72
Count of Fee Adjust	14,373	34,825
Amount of Fee Adjust	5,052.03	13,583.58
Count of Qty Adjust	34	120
Amount of Qty Adjust	22.74	159.14
Count of $50 Presc.	-0-	-0-
Amount of $50 Presc.	-0-	-0-
Average Cost Per Presc.	3.90	3.87

Most providers obviously look at the program from their particular viewpoint but local involvement has now brought to them the administrative problems that exist with a program this size. We know they have a much better realization of the fact that other people have problems which interlock and require a mutual solving and working out of the details. To date I think the demonstration of this project has assisted in that manner.

ADMINISTRATION

By Boyd Thompson
Executive Secretary,
San Joaquin Foundation for Medical Care

The various services rendered under the San Joaquin Pilot Project are reimbursed from several sources.

The administrative costs are actual costs incurred and are not part of the dues. "Dues" are the amount of money agreed to under the contract for the payment of physician services rendered to Group I recipients (except recipients of OAS) in the four county area.

Each month, the four County Public Assistance offices give us a list of the numbers of eligibles by aid category. These lists are compiled and sent on to the Department of Health Care Services. For each Group I AFDC recipient we receive $12.25.

After the total liability under the contract has been identified and the services for which we are liable paid, any money remaining from the dues plus the interest earned by that money will be returned to the State. In the early months of the contract, we were prepared to make a guess as to how much the unused portion of the dues would be.

In recent weeks, however, it has come to our attention that there may be a considerable number of bills for services rendered to Group I recipients of our four counties that have been billed directly to California Blue Shield and paid by them. We are in the process of working with the State and Blue Shield in an attempt to identify these claims.

The administrative costs are not part of the dues and are billed separately according to the type of service rendered. The costs of the prior authorization program are billed directly to the Department of Health Care Services. The cost of the prepayment portion of the contract (those costs directly relating to physician services) are billed directly to the Department of Health Care Services.

In general, the cost of handling bills for all other providers of service is billed to Blue Cross-Blue Shield. Administrative costs for special projects are billed either to the State or added to the over-all administrative costs that are billed to Blue Shield.

In November, 1967, it was necessary to put together a staff and the criteria and procedures that were to be used beginning two months later, January 1, 1968. Due to a five month delay in determining the method of funding the

Electronic Data Processing portion of the program, it was necessary to develop and operate a manual system for the compiling of statistics and reporting.

It wasn't until May, 1968, that the conversion to EDP began, causing a complete duplication of material already collected on patient profiles. As you have already seen, these profiles are rather comprehensive, and are programmed to show all services rendered with the exception of dental.

The first computer runs were available in October and a manual operation was continued until we could verify that the information coming off the computer was accurate.

We have tried to review our administrative procedures and costs in the light of a mature contract. We realize that there will always be need for exploration in pilot projects, but even taking into consideration prudent, moderate, continued exploration, it is feasible to look ahead to an administrative cost of approximately 48¢ per document.

What does this figure mean in the light of our experience of the first eleven months? The document cost for the first 11 months, excluding prior authorization which must be dealt with separately, was 68½¢ per document. Our start-up costs which include EDP programming and all of the duplication of administrative effort is 22% of this document cost, or 15¢ per document. This leaves the first year's cost at 53½¢ per document. This cost includes the cost of special reports and projects asked for by the Department of Health Care Services.

In discussing our administrative costs, it must be borne in mind that Blue Cross and Blue Shield have additional costs in the processing of claims from providers other than physicians.

We had originally hoped that part of the presentation would include a cost comparison. This is not possible, however, since comparative data is not yet available.

We are looking forward to an opportunity to report in considerable detail when all the information concerning the first year's program is available. Our report at that time should include a considerable amount of comparative data. We have retained a consultant, Mr. Maurice Gershenson, who will assist us in making our final report as meaningful as possible.

The State derives several benefits from the type of contract represented by this pilot project. The prepayment aspect of the contract gives the State the advantage of a predictable level of expenditures for a specified period of time. The concern for quality and appropriateness of care is a feature of our Foundation for Medical Care activity, not only the San Joaquin Foundation, but in all of the Foundations throughout the State.

The review procedures established produce a by-product which, in the minds of the Foundations, is incidental to the product of overall medical care but cannot be overlooked: that of making sure that there is the most economical use of the tax monies that pay for this care. The report for the first 11 months shows that bills for $77,077.14 were not approved for payment. Any attempt to evaluate the review mechanism by dollars saved must take into consideration the following.

The Foundation has been actively engaged in this activity for many years. The very fact that the Review Committee exists and that the physicians' claims are sent to the local Foundation for review is a deterent to the rendering of unnecessary services. Whereas physician services lend themselves to a qualified local peer review situation, claims for physician generated services are much more difficult to cope with in the review setting.

One of the biggest problems that immediately arose when Medi-Cal started in California was that of eligibility verification. When our pilot project first started, we established a master eligibility file based on the information provided by the four County Public Assistance offices. This file required daily up-dating and if a claim was received for a person not listed in the file, a telephone inquiry was placed to the public assistance office to attempt to verify eligibility.

Our four-county area went to the multi-copy ID card system on October 1. Through December, we continued to maintain a master eligibility file. Currently, the multi-copy ID card system is working so well that this is no longer necessary. The few that we need to check are checked either by telephone or by messenger. We estimate the multi-copy ID card system will be less costly by approximately $4000 per year.

In discussing eligibility, it is interesting to note that our master file shows 55,000 recipients. The eligibility count throughout the year has remained at between 31,000-33,000 persons.

It is interesting to note the daily requests we have from our local public assistance office for patient profiles and our requests for reports from the social workers. This may well be one of the biggest advantages to a program similar to the one we are discussing; the opportunity of having a Medi-Cal consultant and the social service staff of the public assistance office working in close cooperation with the peer review mechanisms established into the program.

Administratively, the biggest problem faced by the Foundation has been to develop an adequate system of claims processing for drugs, as sheer volume of the claims creates a problem, particularly when you attempt to develop a meaningful review technique. No other claims suffered as much as drugs from the inability to develop our EDP program at the very beginning of the contract. The actual billing form creates much of the problem and we are pleased to hear that the Department of Health Care Services is experimenting with a new form that will better lend itself to machine processing.

DOCUMENT COUNT

Provider	Claims Received December, 1968	Year To Date
M.D.	8,739	76,586
Drugs	30,208	260,250
Visual Appliances	599	6,319
D.P.M.	585	2,304
D.D.S.	887	10,273
Hearing Aids	204	2,202
Lay-Lab	344	3,173
Chiropactors	107	1,143
Assistive Devices	101	702
Nursing Home	930	10,242
Hospital	415	3,802
Hospital (Out-Pt.)	164	2,614
V.N.A.	34	309
H.H.A.	83	566
Physiotherapy	25	172
Pro-Devices	33	207
Transportation	81	871
Other	12	106
Total To Date	43,551	381,841

Returned To Provider

Claims 671—Year To Date 12,131

Prescriptions 1,794, Year To Date 6,850

December 31, 1968

TREATMENT AUTHORIZATION REQUEST COUNT

Provider	Authorization Requests Received	Authorization Denied
M.D.	345	9
Drugs	57	25
Visual Applicances	4935	258
D.P.M.	2	2
D.D.S.	292	
Hearing Aids	349	41
Lay-Lab		
Chiropractors	3	1
Assistive Devices	236	68
Nursing Home	3723	20
Hospital		
Hospital (Out-Pt.)		
V.N.A.		
H.H.A.		
Physiotherapy	66	8
Pro-Devices		
Transportation	18	2
Other	16	2
Total To Date	10,042	436

DUES RECEIVED AND AMOUNT PAID BY DATE OF SERVICES

Month	Group I Recipients	Dues Received	Phys. Services Paid
February	22,061	$166,178.00	$135,565.72
March	22,720	170,360.50	148,411.30
April	23,152	173,170.00	155,425.96
May	22,858	171,561.25	147,730.17
June	22,585	170,162.50	118,736.47
July	22,190	168,405.50	134,841.28
August	22,245	168,707.25	123,276.49
September	22,233	169,038.75	138,677.14
October	21,854	166,757.00	63,809.28
November	21,982	167,826.25	3,671,90
December	23,364	176,961.75	—0—
TOTAL		$1,524,340.75	$1,170,145.71

CONCLUSION

By Donald C. Harrington, M.D.
President
San Joaquin Foundation for Medical Care

In summary, we of the San Joaquin Foundation would like to go on record as stating that even if our current problems could never be solved, we feel the program has proved its worth and is of benefit to the State, the patient and the providers.

Secondly, if concern for patient care is to be truly meaningful, this type of approach must be transported to other areas and it is in this regard that we are recommending that other counties be included in this pilot project in one way or another.

What we have done so far in San Joaquin can be done in other areas. What we have accomplished thus far we are most willing to share in every detail with other counties.

I would like to take this opportunity to publicly thank for their cooperation the Department of Health Care Services, the Prepayment Committee of the Health Review and Program Council, and all others that have worked to make this program successful.

The Medi-Cal Pilot Project Prepayment Contract

This Contract is entered into between the State of California, through the Health and Welfare Agency, hereinafter called State, and San Joaquin Foundation for Medical Care, a California nonprofit corporation hereinafter called Foundation.

1. This Contract is entered into on the basis of the following background or underlying facts.

A. Foundation has for about thirteen years been engaged in the field of prepaid medical services. It has three plans wherein it undertakes to furnish the services upon payment of dues. There are several other employer plans which Foundation administers for the employer.

B. State is required to provide medical and related services to certain public assistance recipients pursuant to Division 9, Part 3, Chapters 7 and 8 of the Welfare and Institutions Code. Subparagraph (f) of Section 14000 of said code provides that the State may contract with carriers to establish pilot programs.

2. Foundation agrees to provide physician services to public assistance recipients receiving cash grants and resident of the counties of Amador, Calaveras, San Joaquin, or Tuolumne, other than those persons receiving such grants as Old Age Security pursuant to Division 9, Part 3, Chapter 3 of the Welfare and Institutions Code. The scope of physician services to be provided shall be as set forth in Division 9, Part 3, Chapters 7 and 8 of the Welfare and Institutions Code and the regulations duly adopted applicable thereto, as such code and regulations may read from time to time.

3. The respective county welfare department will have determined the eligibility of cash grant public assistance recipients and will have issued to such recipients appropriate evidence certifying their entitlement to the benefits under the medical assistance program. The respective county welfare departments also will provide Foundation with lists of eligible recipients and will update such information at least monthly. Foundation will verify eligibility prior to approving a physician's claim.

4. The respective county welfare departments will certify monthly the number of cash grant public assistance recipients in each of the covered categories, to wit, Permanently and Totally Disabled, Blind, Potentially Self-Supporting Blind, and Families with Dependent Children. State agrees to pay to Foundation dues on behalf of such cash grant public assistance recipients. The amount of dues per person per month is dependent on the category of public assistance and is set forth in the following table, together with the appropriate code as specified by the State Department of Social Welfare.

Description	Code	Rate
Permanently and Totally Disabled	60	$14.50
Blind and Potentially Self-Supporting Blind	20, 50	$12.25
Families with Dependent Children	30, 35, 40, 45	$ 6.25

5. With respects to the "buy-in" pursuant to Part B of Title XVIII of the Federal Social Security Act, State will have separately paid the applicable premiums for some of the recipients under this Contract and as a result, the cost of physician services for those recipients will be paid under said Title XVIII, subject to a $50.00 annual deductible and a 20 percent co-insurance payment. Under such Title XVIII program, Foundation will be responsible for providing physician services within the $50.00 deductible amount and will be responsible for providing physician services with respect to the 20 percent amount not paid for from the Federal Fund. The effect of Title XVIII has been taken into consideration in fixing the amount of dues under paragraph 4 of this Contact.

6. State will pay the dues to Foundation on the 25th of each month for services for that month and based on the certifications from the county welfare departments as of the first day of the month.

7. Foundation shall provide the Medi-Cal Consultant function for the counties of Amador, Calaveras, San Joaquin, and Tuolumne.

8. In connection with this Contract, Foundation has made arrangements with California Physicians' Service and with Hospital Service of California to do a portion of the processing of claims submitted under the Medi-Cal program by suppliers of some of the services who are not physicians, and as to some other types of services, to receive copies of items for which payments are made. Foundation will correlate the information thus obtained with the information obtained through claims submitted by its physician-members in order to create patient profile records and provider profile records. Each patient profile record will be a record of all services provided to the patient under the Medi-Cal program. Each provider profile record will be a record of all services provided by such provider and paid for through the Medi-Cal program. Through the patient profile records, the provider profile records and the assumption of the Medi-Cal Consultant function, Foundation will attempt to control the utilization of all types of services under the Medi-Cal program. It is this feature and the prepayment feature which are the unique features of this Contract and which makes this project a pilot project within the meaning of subparagraph (f) of Section 14000.

9. The geographical limits of the services to be provided by the Foundation under this Contract are to be based on the residence of the public assistance recipient. If a public assistance recipient resident of another area obtains service from a provider within the Foundation's area and the Foundation receives a claim from a physician or other provider of seryice with respect thereto, Foundation will merely transmit the claim to the appropriate fiscal intermediary. If a public assistance recipient resident of Foundation's geo-

graphical area obtains service from a provider in another area, Foundation will honor the claim to the extent that the claim is for physicians' services and will pay it within the dues amounts received by Foundation. To the extent that the claim is from a provider of services other than a physician, Foundation will arrange with the fiscal intermediary for Foundation to process the claim in the same manner it would have if the provider's place of business was within Foundation's geographical area. In payment of a claim by a physician who is not a member of Foundation, Foundation's geographical area, Foundation will pay according to the 60th percentile schedule supplied by California Physicians' Service and in effect for the time when the service was provided.

10. The amounts which are paid as dues for physicians' services under this Contract are to be used solely in payment of claims of physicians who have provided services to public assistance recipients in accordance with the Medi-Cal program. If it is necessary to prorate approved physician claims, Foundation will pay in full the approved claims of physicians who are not members of Foundation and will prorate the approved claims of physicians who are members of Foundation. If at the termination of the Contract, the total of approved claims is less than the total dues payment, the balance shall be repaid to State. The existence of such a balance shall be determined after all claims for services during that year have been submitted and approved or otherwise settled. Foundation will not approve a fee for a member-physician in an amount higher than would have been approved in 1967.

11. In addition to the payment of dues, State will pay Foundation for its administrative costs in processing claims covered by the payment of dues, in providing the Medi-Cal Consultant function, and maintaining records and furnishing reports. Foundation also will verify eligibility on claims it processes for fiscal intermediary and will be paid under this Contract for the administrative cost of such eligibilty verification. The accounting classificatons to be used are set forth in the attached Schedule A. Foundation will maintain adequate records of claims and of its administrative costs. Foundation's record will be open to inspection by State or Federal representatives during business hours.

12. Foundation shall maintain and provide such records as are necessary for State to meet the requirements for reporting placed on State by the Federal Government. Foundation also shall furnish reports as may be required by State.

13. Foundation represents that it has agreements with physicians who will be preforming the services and that pursuant to such agreements the physicians have agreed to maintain 1967 fee levels, to accept proration in the event of unfavorable experience, and to accept the amount from Foundation as full payment for their services.

14. Foundation will conduct statistical and other research activities in connection with this Contract. Such activities will be defined and payment therefor arranged through a separate contract. Such separate contract shall also set forth the method by which costs are to be allocated between this Contract and the statistical and research contract.

15. This Contract shall go into effect on February 1, 1968. Foundation's liability hereunder shall be based on the date on which services are perfformed rather than when claims are submitted. This Contract shall remain in effect through January 31, 1969, subject, however, to the right of either contracting party to terminate the Contract by written notice to the other party. Such writte nnotice may not be given prior to April 1, 1968, and upon the giving of such written notice, the Contract will terminate at the end of the calendar month succeeding the month in which the notice was given.

16. Upon termination of this Contract, Foundation shall remain liable for the payment for physicians' services performed prior to such termination, and State shall remain liable for the administrative costs of Foundation incurred in processing and settling claims even though such costs are incurred subsequent to the termination.

DATED: January 31, 1968

STATE OF CALIFORNIA
HEALTH AND WELFARE
AGENCY

By.....

SAN JOAQUIN FOUNDATION
FOR MEDICAL CARE

By.....
Executive Secretary

SCHEDULE A

The following expense classifications will be applicable for direct charges:

CODE CLASSIFICATION AND EXPLANATION

0011 SALARIES—Based upon current active rates applicable to program

0012 OVERTIME—Necessary overtime applicable to program

0015 EMPLOYEE BENEFITS—For group Life and Health Insurance at current rates

0016 OTHER PAYROLL EXPENSE—Workmen's Compensation Insurance, Christmas Bonus on accrual basis, F.I.C.A. Tax (Social Security), S.U.I. Tax (Unemployment Insurance Tax) Employee Pension

0021 FORMS AND PRINTED MATTER—Charges to be made based upon actual cost

0022 OFFICE SUPPLIES—Charges to be made based upon actual cost

0026 OTHER MATERIALS AND SUPPLIES—Charges to be made based upon actual cost

0031 TRAVEL AND RELATED EXPENSE—Actual travel for personnel engaged in travel for the program

0032 TELEPHONE AND TELETYPE—Actual charges for installation of trunks and toll charges, answering service and switchboard

0033 POSTAGE AND MAILING EXPENSE—Postage to be charged on an actual basis. Other mailing expense to be on an actual basis

0034 MAINTENANCE AND SERVICE—Actual charges for maintenance and repairs for equipment used in the program

0035 UTILITIES—Actual charges for expenses necessary in program

0036 CONFERENCE, MEETING, AND SUNDRY EXPENSE—Actual charges for expenses necessary in program

0037 FREIGHT—Actual charges for freight applicable to program

0039 OTHER GENERAL EXPENSE—Costs applicable to the program not covered in other classifications

0041 EQUIPMENT RENTAL—For rental of equipment necessary for operation of program

0042 RENT OF SPACE—Actual charge for space required for program

0043 PROFESSIONAL FEES—Actual Legal auditing, Medical Review, Actuarial and other Professional fees applicable to program

0044 DEPRECIATION, FURNITURE AND EQUIPMENT—Depreciation of the cost of furniture and equipment used in program shall be based on cost of acquisition computed at 20% per year until fully depreciated

0046 TAXES—Taxes applicable to program

0047 INSURANCE—Insurance and indirect bond premiums

The following charges will be appliable on an indirect basis. Such charges to be prorated for the following functions:

0051 ADMINISTRATION SERVICES—Charges to be based upon contractors' general practice

0053 PERSONNEL MANAGEMENT—Use 0051 instead

0057 GENERAL ACCOUNTING—Charge to be prorated in a manner consistent with contractors' general practice

0058 MACHINE ACCOUNTING—Charges to be based upon actual job cost for work performed for program. To include consultation, programming, etc.

0061 GENERAL OPERATIONS—Fixed expenses for equipment rental, space, depreciation, professional services, personal property taxes, insurance premiums which would be charged on a prorata basis

AGREEMENT

This Agreement, made and entered into between California Physicians' Service, Hospital Service of California, and Hospital Service of Southern California, hereinafter collectively called "Contractor," and San Joaquin Foundation for Medical Care, a non-profit California corporation, hereinafter called "Foundation," provides:

A. Recitals

1. Pursuant to a written agreement dated February 19, 1966, between the Administrator of the Health and Welfare Agency of the State of California, for said State, and the Contractor, which agreement is hereinafter sometimes referred to as the "Prime Contract," the Contractor performs and renders certain services for the State of California in the administration of Basic Health Care and Extended Health Services for recipients of public assistance, as provided in Chapters 7 and 8, Part 3, Division 9 of the Welfare and Institutions Code.

2. The Foundation has heretofore worked with the Contractor in the performance of Contractor's duties under the Prime Contract, and is qualified and competent to perform certain services required to be rendered under the Prime Contract, and desires to participate to a greater degree thereunder.

3. The Foundation intends to enter into a direct contract with the Health and Welfare Agency, which will establish a pilot program for the underwriting of risk involved, as provided by subparagraph (f) of Section 14000 of the Welfare and Institutions Code, and the within agreement is intended to facilitate the establishment of said pilot program.

B. Terms and Conditions

In consideration of the foregoing recitals and of the mutual promises contained herein, the Contractor hereby contracts with the Foundation, as a subcontractor under the Prime Contract, for the rendering of the services hereinafter described.

1. Scope of Services to be Performed

A. Foundation agrees to perform all those services specified in Section B "2" of the Prime Contract as to bills, invoices and statements for services and other benefits provided to recipients resident in San Joaquin, Amador, Calaveras, or Tuolumne Counties except that the Foundation shall not make payment to any provider. Further, the Foundation shall not act with respect to bills, invoices and statements submitted for services and benefits to recipients who are entitled to health service benefits under both Title 18 of the Social Security Act and under the Medi-Cal program.

B. The Foundation shall perform said services, which services in part include reviewing claims received and determining whether requisites of eligibility and compliance with applicable laws and regulations are met, and determining the price or sum to be paid on account thereof, performing said services as to all providers except:

(1) The Foundation shall not administer or receive claims for hospital services currently being billed to Blue Cross. The Contractor will furnish the Foundation with a copy of each claim paid on account of such services to recipients who are within the scope of this agreement, for record purposes.

(2) The Foundation shall determine eligibility only as to claims for dental services and shall then submit said claims to California Physicians Service for further administration, and

(3) The Foundation shall not determine the price or sum to be paid as to skilled nursing home services, or home health services, and such determination shall be made by Contractor.

2. The Foundation shall further approve or disapprove claims for payment, and shall submit all claims which it approves for payment to the Contractor, which shall pay said claims. As between the Foundation and the Contractor, the Contractor shall be entitled to rely upon the approval of the Foundation, and ultimate responsibility for loss to Contractor on account of any such payment shall be assumed by the Foundation.

3. The Foundation shall also do and perform such acts as the Contractor may be required to perform under the Prime Contract, or any provisions thereof, to the extent that such actions are necessary to carry out the purposes and provisions of the Prime Contract as to the services to be performed under this subcontract. The Foundation shall save and hold harmless the Contractor, California Physicians' Service, Hospital Service of California, and Hospital Service of Southern California, and each of them, from any loss, claim, suit, penalty or damages arising by reason of the Foundation's activities under this sub-contract or by reason of any misconduct, negli-

gence, tort, contract, or wrongful act by the Foundation. The Foundation shall not assign or subcontract any right or obligation hereunder.

4. Term of the Agreement

This agreement shall be effective as of the 1st day of January, 1968, as to services rendered on or after said date, and shall be in effect until cancelled by either party upon sixty days notification to the either, except this agreement shall terminate in the event that the Prime Contract is terminated by either party thereto, as of the date the Prime Contract is terminated.

5. Costs and Reimbursement

The Foundation shall be paid and reimbursed for its services and costs hereunder to the same extent and upon the same basis as the Contractor is entitled to payment from the State for services and costs of like kind and character under the Prime Contract, and subject to such limitation on reimbursement of administrative costs as may be established from time to time by agreement between the Contractor and the State. The Schedule of Allowable Administrative Costs contained in the Prime Contract is by this reference incorporated herein. In the event that Contractor is required to make any payment or refunds on account of payments made by Contractor to Foundation, Foundation shall reimburse Contractor. The Foundation shall submit its invoice for reimbursement to the Contractor, and shall be reimbursed in the same manner and as the Contractor is reimbursed under Section B "4" (j) of the Prime Contract.

6. Approval by the Administrator

This agreement shall not be effective unless written consent is given by the Administrator of the Health and Welfare Agency, and shall be terminated in the event that the Administrator withdraws his consent such withdrawal to be by written notice to the parties effective sixty (60) days after the date thereof.

7. By this reference, all terms, conditions and requirements of the Prime Contract are incorporated hereunder, and the Foundation agrees to comply therewithin each and every respect, except that this provision shall not enlarge the character or scope of claims to be administered by the Foundation.

8. Fair Employment Practices

Contractor agrees to be bound by, and to comply with

(a) Standard Form 3, Fair Employment Practices Addendum, a copy of which is attached to, and by this reference made a part of this agreement; and

(b) Regulations and requirements in the field of Nondiscrimination in Employment imposed by the government of the United States upon persons or corporations performing the functions undertaken by Contractor under this agreement.

IN WITNESS WHEREOF, this agreement has been executed by and on behalf of the parties hereto.

CALIFORNIA PHYSICIANS' SERVICE, A CORPORATION

By_____

_____
Title

HOSPITAL SERVICE OF CALIFORNIA
A CORPORATION

By_____

_____
Title

SAN JOAQUIN FOUNDATION FOR MEDICAL CARE, A CORPORATION

By_____

_____
Title

HOSPITAL SERVICE OF SOUTHERN CALIFORNIA
A CORPORATION

By_____

_____
Title

APPROVED BY
STATE OF CALIFORNIA, HEALTH AND WELFARE AGENCY

By_____

PROPOSAL FOR A STUDY OF MEDI-CAL SERVICES UNDER DIVERSE ORGANIZATIONAL MODES

Division of Medical Care Organization
School of Public Health
University of California, Los Angeles

July 5, 1968

INTRODUCTION

The California Medical Assistance Program, known as Medi-Cal, is California's implementation of Title XIX of the Social Security Act. One of the first state plans approved by the U.S. Department of Health, Education, and Welfare, it has been in operation since March 1, 1966. It offers a broad program of comprehensive health care for over one million public assistance recipients and a somewhat narrower range for about 200,000 medically indigent individuals. Medi-Cal services are provided under a variety of modes of medical care, including solo fee-for-service practice, OEO Neighborhood Health Centers, county hospitals and outpatient departments, private group practices, and a four county prepayment plan.

There is much controversy but little information regarding the effectiveness and efficiency of the many modes of delivering health services to the poor. We propose to study various ways in which services are delivered under Medi-Cal, and to determine whether there are significant differences in the quality, quantity, and costs of the services provided under these modes.

Six settings representing diverse organizational modes of delivering services to Medi-Cal beneficiaries have been identified and are proposed for study. All of the modes provide care to a defined population for whom defined services are available under the Medi-Cal program. Each is a prototype of either innovative or traditional patterns of medical practice. They are:

1. The San Joaquin Medical Care Foundation Prepayment Plan.

   A contractual arrangement for prepayment of solo fee-for-service care, with unique features of utlization review and control. It covers public assistance recipients in one medium sized county (San Joaquin) and three small rural counties (Amador, Calaveras, and Tuolomne).

2. A comparison county, roughly comparable in size and socio-economic characteristics to the San Joaquin four-county complex but without prepayment and the unique review and control features of the prepayment plan.

3. The Watts Neighborhood Health Center.

   An OEO center affiliated with a medical school, in an urban ghetto environment, providing Medi-Cal services under a cost-reimbursement formula.

4. The King City Neighborhood Health Center.

   An OEO center operating under a private group practice arrangement, in a rural environment. Medi-Cal reimbursement is expected to begin soon under a cost-reimbursement formula.

5. Harbor General Hospital Outpatient Department.

   A unit of the Los Angeles County hospital complex, offering comprehensive services to eligible residents of the southern portion of the county, under a cost-reimbursement formula.

6. One or more large, private, group practices.

   Over thirty such groups in Los Angeles County have been identified as having at least five full-time physicians representing at least three specialties. A group, or a sample of groups, providing services to Medi-Cal beneficiaries will be selected for study. Medi-Cal payments are on fee-for-service basis.

PURPOSE OF THE STUDY

The purpose of this research is to examine the quality, use, cost and outcome of services provided to Medi-Cal beneficiaries under diverse organizational modes of delivery of care, and to determine whether significant differences in these variables are associated with differences in the modes of care, (a) among the modes and (b) in comparison with the state Medi-Cal program as a whole.

It should be noted that the focus of this study is the impact of organizational pattern upon Medi-Cal services. The effects of Medi-Cal upon the delivery system itself or on other consumers and services, while important areas of concern, are not within the scope of this inquiry.

The following questions, though not intended to be final in detail or scope, indicate the objectives of the data to be obtained.

I. CHARACTERISTICS OF THE ORGANIZATIONAL MODES

What are the distinguishing characteristics of each mode in relation to type of organization, method of remuneration, criteria for provider participation, agreements with providers of service, beneficiary access to the system, authorization procedures, medical review, etc., which differ from those of

1. other modes,
2. the general Medi-Cal system?

II. PROVIDER CHARACTERISTICS AS INDICES OF QUALITY

A. Among the physicians providing Medi-Cal services in the various settings, are there significant differences in the proportions of

1. general practitioners, board-certified specialists, and other practitioners?
2. graduates of California, other U.S., and foreign schools of medicine?
3. lengths of time since medical graduation?
4. age distributions?
5. teaching appointments?

B. What variations occur in the volume of Medi-Cal services provided (as measured by dollar payment and units of service) within the above classifications?

C. What proportions of specified services (e.g., elective surgery) are performed by general practitioners and by specialists?

D. Among physicians, for what proportion are certain indicative ratios outside the norms of practice; e.g., ratio of injections to visits, prescription to visits, routine office visits per patient, diagnostic procedures per patient for selected diagnoses, etc.?

E. Among hospitals used by Medi-Cal patients served by the various settings, what proportion are accredited? What proportions are proprietary, voluntary non-profit, county-owned?

F. What proportion of nursing homes used by the setting's Medi-Cal patients are certified ECF's?

G. What proportion of claims are screened by medical review procedures? Of these, how many are rejected or adjusted, and for what reasons?

III. USE OF SERVICES (Quantitative and Qualitative)

A. Among eligible persons, within age-sex groups, what are the rates of use and proportions using

1. major types of service; e.g. physician services, hospital inpatient care, nursing home care, drugs, dental care, etc.?
2. selected preventive medical services; e.g. physical examinations, (immunizations, chest x-rays, Papanicolau smear, etc.)?

3. selected therapeutic and diagnostic services; e.g. physician's visits (by type and place of visit), specified types of surgery, x-ray and lab, dental procedures, drugs, etc.?

B. Among patients using physician's services.

1. were norms of fiagnostic and therapeutic procedures provided those with selected diagnoses?
2. was drug prescribing within accepted norms for selected diagnoses?

C. What proportion of total inpatient admissions and hospital days were in

1. accredited hospitals?
2. proprietary, non-profit, and county hospitals?

D. What proportion of hospital stays for selected diagnoses were outside norms or experience for those diagnoses?

E. What proportion of nursing home days of care were in ECF's?

F. What health services not covered by Medi-Cal are offered by the mode and what is the extent of their use by Medi-Cal beneficiaries?

G. What are the demographic characteristics of eligible persons

1. who used specified services?
2. who did not use them?

H. Among users of the various settings, what are the patients' opinions of

1. availability of service?
2. adequacy of care?
3. problems in use of the service?

IV. COSTS (TO MEDICAL-CAL)

A. Are there significant differences in average payments, ranges and frequency distributions of costs for specified services, procedures, and diagnoses

1. per eligible person (age-sex related)?
2. per person using the service (age-sex related)?
3. per unit of service?

B. Do any differential patterns of cost emerge, for substitutable or complementary services, such as hospital vs. outpatient care, home health vs. hospital care, etc.?

V. OUTCOME

A. Short-term

1. What is the percentage distribution of age-sex related discharge status (home, nursing home, another hospital, death) for hospital discharge? Nursing homes?
2. Infant mortality and maternal mortality rates.

B. Long-term:

Morbidity and mortality age-sex specific rates.

SAN JOAQUIN FOUNDATION FOR MEDICAL CARE

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APPENDIX C

CHAP

Certified Hospital Admission Program

A prospective hospital utilization program combining preadmission and concurrent peer review to determine medical necessity for hospital admission and for length of stay.

Developed by the Medical Care Foundation

of the Sacramento County Medical Society

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FOREWORD

DEVELOPMENT OF A CERTIFIED HOSPITAL ADMISSION PROGRAM (CHAP)

The recent rapid escalation of costs for medical and hospital services has caused great concern to the Medical Care Foundation of Sacramento. At a time when we wished to be developing more comprehensive health plan coverages we were faced with rapid increases in premiums in the plans we now sponsor without any upgrading of benefits.

Our Research and Development Committee was given the assignment to find a way to increase benefits including outpatient care, preventive care, psychiatric care and full coverage for hospital and maternity, without increase in premium! James Schubert, M.D., Chairman, Frank Schiro, M.D., and I held many joint meetings with our Foundation staff and Leon Hyman and his associates at California-Western States Life Insurance Company. We explored many possible avenues and finally settled on increased control of hospital costs as the one factor which could offer the greatest possibility in reaching our goal.

We then began working closely with the administrators from Sacramento's principal hospitals: Sutter General, Sutter Memorial, Mercy San Juan and American River. We evaluated possible ways of reducing hospital expenses. We found that the hospitals were concerned about retrospective utilization controls which denied payment on hospital bills after the service had been rendered. We knew the unhappiness and anger experienced by patients who had to pay unexpected hospital bills because of such retrospective utilization controls.

The experience with both our Foundation and Medical Society Insurance Review Committees has been that the doctors look toward protecting the patient and hospital on claims brought to the committee since the bill had been incurred and it is often more difficult to deny payment. It then seemed obvious that the next stop was to develop a prospective or current utilization review. A system was thus developed that would allow pre-hospitalization certification on elective admissions and current evaluation of emergency or urgent cases.

The following pages explain in detail the current system, referred to as CHAP, which we have in effect at present for both Medi-Cal (Medicaid) and the MCF's commercial programs.

James C. Bramham M.D.

JAMES C. BRAMHAM, M.D., *President*
Medical Care Foundation of Sacramento
AN ORGANIZATION OF
THE SACRAMENTO COUNTY MEDICAL SOCIETY

MEDICAL CARE FOUNDATION

The Medical Care Foundation (MCF) of Sacramento is a corporate organization of the Sacramento County Medical Society with an enrollment of 500 of the 700 private practitioners in Sacramento and El Dorado counties. Its chief function has been the establishment and approval of minimum standards for the health insurance programs underwritten by commercial carriers. The MCF not only provides minimum benefit standards but also administers MCF-approved health plans by direct payment of claims since it receives and processes all claims and provides the peer review mechanism for disputed physician and other provider claims. A recent major undertaking of the MCF has been the management and staffing of a Regional Claims Office for the Title XIX Medicaid program, Medi-Cal in the State of California, under a sub-contract with the Department of Health Care Services and California Blue Shield.

DEVELOPMENT OF THE FOUNDATION COORDINATED HEALTH PLAN (FCHP)

The Sacramento County Medical Society Board of Directors and the MCF Board of Trustees have felt the need of a comprehensive private health insurance plan that could be presented at a reasonable premium, that allows for freedom of choice of physician and hospital, that is adaptable to various consumer groups and that would be supported by both insurance industry and the medical profession.

The FCHP was developed jointly with the Cal-Western Life Insurance Company and the MCF. The joint task force met weekly over a period of six months to develop the parameters of the the plan. Special consultants were called upon in certain areas. The final prototype was approved by the Insurance Commissioner of the State of California. Although developed jointly with Cal-West, it is available to all health insurance carriers. From FCHP has evolved our Certified Hospital Admission Program (CHAP), described below and referred to hereafter.

DEVELOPMENT OF CERTIFIED HOSPITAL ADMISSION PROGRAM (CHAP)

In order to avoid an unmarketable premium rate and yet provide the comprehensive benefit structure, it was felt necessary to find some mechanism whereby significant savings could be made which, in turn, would pay for the extensive benefits not usually available in health plans. These include total maternity, outpatient medical and surgical, diagnostic laboratory, and x-ray and hospital care for "medically necessary conditions." Annual examinations and extended care facility coverage are also included.

Analysis of medical costs shows that at least 60 cents of each benefit dollar is spent on inpatient hospital services. Additional studies have shown a significant variance in "hospital days used" per year under various insurance carriers. One comparative study showed a variance as follows:

HOSPITAL DAYS USED PER 1,000 INSURED PER YEAR

Cal-West	@	1,000 days
Blue Shield	@	875 days
Closed Panel Plans	@	515 days

Among the factors affecting the length of stay and the incidence of hospitalization is the severe limitation some insurance plans place on outpatient benefits; hence, "diagnostic" admissions often occur in order to obtain coverage for services which otherwise could have been obtained in the office or outpatient lab. Lengths of stay are closely controlled in closed panel plans because of the capitation factor in physician group contracts. The fewer days in the hospital by the capitated group means a greater surplus for distribution. A built-in incentive for economy is present.

We felt that in addition to the extensive outpatient benefits available which would tend to lessen the hospital days, a more effective mechanism would be to attack the problem of the length of stay of patients once they are admitted. If the length of stay could be significantly shortened, sufficient savings could be generated to pay for the broader benefits of the plan, yet still pay in full the hospital bill for "medically necessary admissions."

Experiences within the existing peer review mechanism already functioning for standard MCF-sponsored plans and the Medi-Cal Regional Claims Program dictated that any effective hospital utilization plan must be carried out *prior to* and *during* hospitalization and not after discharge. The major hospitals in the community developed jointly with our task force the structure and procedures for certification of the hospital stay.

The report of the *Commission on Professional and Hospital Activities* (Ann Arbor, 1969) is the prime reference currently used by the MCF to determine a reasonable length of stay. This report studies some 16 million discharges from 972 hospitals in both pre- and post-Medicare periods. The most recent study was completed in June 1969. The study correlated data in 183 diagnostic groups and 177 operative procedures, dividing the length of stay into various percentiles according to age groups.

As indicated in the following examples the 50th percentile means that 50 percent of the patients with that diagnosis or operation were discharged on or before the day listed opposite the age group category.

To find initial number of days allowable, the coordinator refers to the Statistical Study (PAS Study in Sacramento Project) and uses the 50th percentile days for that age group, i.e.:

CODE 79—ACUTE CORONARY OCCLUSION

Single Dx. Age	Avg. Stay	Percentile 5th	10th	50th	75th	90th	95th
0-19	11.7	1	1	**5**	24	29	29
20-34	18.6	3	6	**20**	24	29	32
35-49	20.3	6	9	**20**	25	30	35
50-64	21.2	7	10	**21**	26	32	37
65-+	22.1	7	11	**21**	27	34	39

CODE 284—CHOLECYSTECTOMY

Single Dx. Age	Avg. Stay	Percentile 5th	10th	50th	75th	90th	95th
0-19	10.2	6	6	**9**	12	15	17
20-34	10.0	6	7	**9**	11	14	17
35-49	10.6	6	7	**9**	12	16	18
50-64	11.7	7	7	**10**	13	18	21
65-+	15.0	8	8	**13**	18	24	29

An additional length of stay study by the California Health Data Corporation is being used to supplement the PAS statistics due to local variations.

Data developed by the MCF is used to modify lengths of stay where community practice differs significantly from the PAS and CHDC Studies.

Since the primary aim of the Certified Hospital Admission Program is to provide adequate, quality medical care, the simple arbitrary determination of length of stay by a claims office clerk was not felt to be desirable. *Nurse Coordinators* as well as *M.D. Certification Consultants* were appointed to administer the peer review mechanism as it applied to the Certified Hospital Admission Program.

Although medical necessity would determine actual length of stay, an actuarial study led us to believe that a critical time in the length of stay would be the 50th percentile in the PAS report. Our major efforts then are aimed at a discharge prior to this day; that is, the 50th percentile for that particular diagnosis or surgical procedure.

Hospital utilization review for Medicare comes at 12 days and, in the Medi-Cal program, prior to April 13, 1970 at 8 days. However, under CHAP the review process begins, at the time of admission or earlier; and, is continuous during the patient's hospital stay, thereby precluding the problems which arise from retrospective review.

In early April 1970 the MCF, California Blue Shield and the Department of Health Care Services entered into a contract to administer CHAP for all Medi-Cal patients hospitalized in Sacramento hospitals. All hospital admissions are certified as to medical necessity and length of stay by the MCF. Claims submitted without proper certification are not honored by the fiscal intermediaries.

Each Sacramento physician is assigned to an MCF Advisor who is responsible for certifying medical necessity and initial length of stay. In most cases the requests for certification are actually processed by the Nurse Coordinators assigned to each hospital. Admissions are initially certified to the 50th percentile. Elective admissions are certified by advance mail (see physician instructions). Extensions beyond the 50th percentile requested for medical reasons are reviewed by the MCF Advisors. Consultants may be asked to review the patient's status prior to decisions or extension of hospital stays.

Emergency and urgent admissions are also certified by the MCF on the first working day after admission. Again, if the admission is one that is medically necessary, the certification procedures are essentially the same as the elective cases.

Following are procedural instructions prepared by the MCF for administration of CHAP on a day to day basis.

These instructions are separated into sets specifically directed to Physician's Office, The Hospital and the MCF Registered Nurse Certification Coordinator.

INSTRUCTIONS FOR PHYSICIANS AND MEDICAL ASSISTANTS

A. Elective Admissions

1. Schedule admission and surgery in hospital as at present.
2. Complete Certification Request form (Exhibit "A") (or other approved form as may be required).

   Be sure to include following:

   (a) Patient's complete name, age and sex.
   (b) Patient's I.D. number or group number.
   (c) Diagnosis and surgical procedures planned.
   (d) Date of admission, hospital and date of scheduled surgery.
   (e) Physician to sign form.
3. Send all copies to: Foundation Office, Attention: "Certification Desk."
4. By return mail you and the hospital will receive one "certified" copy showing initial length of stay.
5. Should certification be denied and you wish clarification, call the Certification Desk.
6. Diagnostic admissions will be denied payment unless:

   (a) The diagnostic procedure requires hospitalization (i.e., myelography, bronchoscopy, etc.).
   (b) The patient's physical condition precludes outpatient diagnostic studies.
   (c) Diagnostic admission for convenience of patient or physician will not be "Certified" except as in (a) and (b) above.

B. Emergency or Urgent Admissions

1. During regular working hours (Monday through Friday).

   (a) Phone Certification Desk.
   (b) Prepare Certification Request form (Exhibit "A").
   (c) Deliver all copies to Hospital Admissions Office at time of admission or as soon thereafter as possible.
   (d) MCF Certification Coordinator will verify certification of initial length of stay at the hospital and return one copy to you.
2. During night time, weekends and holidays:

   (a) Complete Certification Request form in hospital. The Hospital Admission Desk *may* do this for you. However, you must sign form prior to first working day following admission.
   (b) Certification Coordinator must be notified of admission by hospital on first working day following admission.
   (c) Have your staff notify MCF Certification Desk of such admission on first working day.

NOTE: It is *not* necessary to have a complete Certification Request form in cases of bonafide emergency or urgent conditions prior to admission. Take care of your patient first and the Certification Request form later.

Following is the definition of Emergency adopted for use in this program:

"Emergency refers to those services rendered under unforeseen conditions which require hospitalization, or admission to a nursing home or convalescent home, or services for the repair of accidental injury, relief of acute pain, elimination of acute infection, protection of the public health, or the amelioration of illness, which if not immediately diagnosed and treated would lead to disability or death, excluding emergency dental services as defined in Section 51061."

All Emergency Admissions are subject to MCF Review and will be validated at time of discharge as to medical necessity and length of stay.

C. Extension of Hospital Stay

1. If your patient requires extension of the length of stay originally granted, *for medical reasons*, contact the Certification Coordinator assigned to the hospital or the MCF Certification Desk.
2. The hospital and/or the attending M.D. may initiate the request for extension on the Certification Request form, but only the M.D. attending the patient may sign the request.
3. If previously anticipated weekend or holiday discharge is cancelled because of a change in the patient's condition which necessitates further hospitalization contact the Certification Coordinator or the MCF Certification Desk on the first working day following.
4. If extension of length of stay is denied by your MCF Advisor and you wish to appeal, contact the MCF Certification Desk. A consultant may be appointed to review your patient.

D. Final Validation of Certification Request Forms Showing Total Days of Hospitalization Approved for Payment

1. Immediately following discharge, copies of the last Certification Request form will be stamped by the MCF Coordinator to show the total days

of hospitalization approved for payment. A copy of the validated Certification Request form will be furnished to the attending physician and to the hospital for submission with their billings.

E. Billing for Physician Services in Conjunction with Hospitalization

1. Complete the billing form as usual.
2. Attach your copy of the MCF validated Certification Request form.
   (a) The validated copy of the form will be sent to the attending physician's office at time of discharge from hospital. For prolonged hospitalization you may request interval validation for billing; contact MCF Certification Coordinator in hospital for this.
   (b) Assistant surgeons or anesthesiologists should obtain a copy of the validated form from hospital or attending physician's office and submit this copy with their billing.
3. Attach copy of patient's Eligibility Card if applicable.

NOTE: Certification of Hospitalization *does not* insure eligibility of patient in program. Please make every effort to send copy of patient's Eligibility Card with billing where applicable.

F. Certification Coordinators

MCF Registered Nurses are assigned to each hospital to assist you in the orderly management of your patient's hospital stay. They are in the hospital to help you and your patient. Your cooperation with them is anticipated.

G. Preadmission Consultations and Consultations to Determine Extension of Length of Stay May Occasionally Be Required Under Certain Circumstances by the MCF

You will be notified should this be necessary.

INSTRUCTIONS FOR HOSPITALS

A. Elective Admissions

1. Physician schedules surgery or admission according to usual or standard procedures.
2. Physician completes and submits Certification Request form to MCF Office.
3. MCF Office sends copy of this form to Hospital Admissions Office *stamped* with initial certification and length of stay.
4. Hospital notifies its MCF Certification Coordinator of admission on first working day after patient is admitted.

B. Emergency or Urgent Admissions

1. Accept patient without complete Certification Request form.
2. Complete Certification Request form at time of admission if attending physician has not already done so. Physician *must* sign before forwarding to MCF Office.
3. Notify MCF Certification Coordinator assigned to hospital or MCF Certification Desk on first working day after such emergency admission.

C. Certification of Medical Necessity and Length of Stay

1. Initial MCF certification of length of stay and medical necessity is based on admitting diagnosis.
2. Final MCF certification of hospital stay before submission for payment is required and is based on final diagnosis explaining hospitalization.
3. Length of Hospital Stay initially certified may be modified depending on patient's condition.

D. Certification Coordinators

1. MCF Registered Nurses, referred to as Certification Coordinators, are assigned to your hospital to assist you in the proper administration of the Certified Hospital Admission Program.
2. They are responsible to the MCF and the agency or organization providing coverage in the discharge of their specific duties.
3. All inquiries concerning patients should be directed to them or to the MCF's Certification Desk in their absence.

E. Extension of Hospital Stay

1. Hospital or the attending M.D. must initiate the Certification Request form and explain the medical necessity of extension. Attending M.D. *must* sign the form.
2. The Certification Coordinator will contact the attending M.D.'s MCF Advisor for approval or extension.
3. If extension of length of stay is denied, the attending M.D. may request a special consultation by the MCF.

F. Final Certification of Form

1. Total days payable will be validated by the Certification Coordinator at time of discharge. This completes certification process and indicates that the hospitalization was necessary and that the length of stay was properly based on final diagnosis and/or procedure.
2. Interim certifications may be arranged should billing practices of the hospital require such in cases of prolonged care (beyond 30 days), and where diagnosis or medical necessity is certain.
3. Certification does not preclude rejection of specific charges on the hospital bill where the charge does not meet applicable guidelines, *standards or contract benefits.*
4. Validated copy of final Certification Request form must accompany hospital billing in order for payment to be made.

G. Daily Census

1. Hospital must provide MCF Coordinator with accurate daily list of patients in their facility falling under this program.

INSTRUCTIONS FOR REGISTERED NURSE CERTIFICATION COORDINATORS

A. MCF Certification Desk

1. Receives phone request from M.D. or hospital for urgent and emergency admission; obtains necessary data.
2. Receives completed request for Certification Request form from M.D. or hospital.
3. Reviews all forms for completeness and makes preliminary review of medical necessity.
4. Certifies all requests of physicians who have been approved for automatic certification by MCF Advisor or Reviewer. Initial certification to 50th percentile PAS Study or other appropriate criterion for Diagnosis or Operative Procedure.
5. Refers to MCF Advisor-Reviewer all requests from physicians not granted automatic certification. (Full-Review list plus others—where requested by Medical Advisor).
6. Returns original to physician stamped *Certified* or *Denied.*
7. Logs all approved requests according to hospital.
8. Logs all denied requests according to physician; retains one copy of form in physician file when denied.
9. Receives, records and reviews all requests for Hospital Certification Extensions when Nurse Coordinator not available in hospital. Notify Advisor of request after all information is obtained, then proceed as directed by Advisor.
10. Receives and records on Hospital Log validated and certified form on discharge of patients from Nurse Coordinator in each hospital. Retain one copy of Certification Request form in Hospital File according to date of discharge.
11. Receives from Hospital Coordinator daily report on Medi-Cal patient census in each hospital. Records all emergency admissions on Hospital Logs.
12. Mails original copy of validated Certification Request form to physician's office.

B. Hospital Certification Coordinator

1. Forwards to Hospital Admission Office one copy of all Certification Request forms for elective admissions.
2. Receives all Certification Request forms from Admission Office for emergency admissions since last regular working day.
3. Verifies actual admissions previously scheduled for admission.

4. Verifies from hospital chart, charge nurse, attending physician and/or patient, the actual physical condition and admitting diagnosis on all emergency (non-scheduled) admissions by *all* physicians, and *all* admissions on *full review* or where requested by Advisor. Verifies that elective surgical procedure is performed as expected and that diagnosis is confirmed.
5. Determines length of stay to 50th percentile of PAS or other appropriate criterion on all emergency admissions based on admitting diagnosis or procedures. Enters this on Certification Request form prepared by hospital.
6. Maintains calendar file on all patients. Reviews patient's condition at least 24 hours prior to end of 50th percentile in order to assist attending physician in obtaining extension where obviously needed.
7. Validates Certification Request forms at time of discharge after verifying.
   (a) Final diagnosis explaining hospitalization.
   (b) Medical necessity for hospitalization.
   (c) Length of stay.

   One copy each for hospital, attending physician and MCF Office.
8. Assists attending physician to obtain certification.
9. Receives requests for extension of hospital care from attending physician or hospital.
   (a) Obtains maximum information regarding patient's condition from nursing personnel and attending physician as to need for extension of length of stay.
   (b) Contacts MCF Advisor for that attending physician for approval of extension.
10. Conducts education program in certification procedures for hospital personnel, especially charge nurses and admitting office personnel.
11. Records in detail any unusual incidents, complaints by physicians, hospitals or patients. Transmit to Management Committee through MCF Manager all such incidents.

RESULTS OF CHAP

It is obvious that total savings in any program, government or commercial, comes from a reduced number of admissions *and* reduced lengths of stay. Statistically valid data is being developed and will be available in the near future.

A. FCHP (Commercial Program)

An apparent reduction of hospital days was recorded. Prior to the CHAP system the enrollees used a total of 6.5 percent over the 50th percentile days based on the PAS Study. Since the program has been in effect the number of hospital days used has been 20.6 percent below the 50th percentile, or a total of 27.1 percent apparent reduction in hospital days used.

Due to the small number of hospitalizations generated under this plan to date, the utilization figures developed do not have true actuarial validity, therefore, no firm conclusions can be drawn from them. They do, however, indicate a definite trend.

B. Medi-Cal

Due to the greater number of hospitalizations occurring under the Medi-Cal Program in Sacramento County, the statistics developed to date do approach an actuarially valid base from which conclusions can be reasonably drawn.

As you will note on the enclosed charts, a reduction of approximately 20 percent in the average hospital stay for Medi-Cal eligibles under the CHAP Program was achieved.

Also notable is the drop in the average daily medical census in those hospitals where prior records of this type had been kept prior to institution of the CHAP control system for Medi-Cal in Sacramento County on April 13, 1970. One major hospital has experienced a drop in average daily Medi-Cal patient census from 50 to 36. This particular aspect of CHAP is undergoing closer study at this time in order to accurately determine the actual overall reduction in the number of admissions experienced. It is anticipated that CHAP-verified hospital claims will be significantly expedited for payment since such claims will have already been audited for medical necessity of stay. Results of this study will be made available to interested parties upon completion.

For preliminary figures on CHAP results to date, see the supplemental material in the back of this booklet.

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